FINANCIAL POLICY

Most insurance plans cover the cost of the visits, less any applicable co-pays, co-insurance, and deductibles. It is your responsibility to: check with your plan in advance to ensure that we participate with your insurance plan, review your benefit coverage; and ensure all pre-approval requirements are met to avoid denials or out-of-network benefits.

In summary, your financial responsibility pertains to:

1. For your convenience, we accept cash, checks, and most major credit cards. Please note that there is a $25.00 service charge for all returned checks and, if a check is returned for insufficient funds, the practice will no longer accept checks for payment from the individual.
2. We will collect your deductible, co-pay, uncovered services or the percent you are responsible for at the time of your visit. Please be prepared to pay at the time of check-in before you are seen by the provider. If you do not have your payment, you may be asked to reschedule. It is the patient's responsibility to know the terms of their insurance plan.
3. You must bring your insurance card and photo I.D. with you to every visit as well as any authorization information your insurance may require. Policies change frequently and we must have these to identify correct claims processing and avoid possible payment delays from your insurance payer. Without these, you may be asked to reschedule.
4. Medicaid consists of five different bayou health plans. If you have Medicaid, you will need to present the card associated with your specific plan at every visit. Please be advised, our office can only accept Medicaid if it is secondary to another insurance payer.
5. If your insurance leaves a balance for patient responsibility or denies payment on your account, you will be asked to pay by check, cash, or charge. You may also pay your bill online through your patient portal. If you do not pay in a timely fashion, your account may be placed into Bad Debt status and no appointments will be scheduled until paid in full. If you fail to meet the financial obligations agreed upon in this financial policy or have not made other payment arrangements with our billing department, your outstanding balance will be sent to a collection agency. You will be required to pay your entire balance and any collection agency fees, up to 25% of your account balance, before being scheduled for any further appointments.
6. In accordance with AMA CPT guidelines, we reserve the right to charge for telephone calls with our medical professionals that include evaluation and management of your medical condition. We will bill your insurance for such calls, but if it is not covered by your plan, you may be responsible for the charges.
7. **TRICARE, HMO or PPO PATIENTS REQUIRING A REFERRAL**: You are responsible for making sure your visits with our office are authorized by your primary care physician or manager (PCP/PCM) or insurance payer. This authorization must be obtained *before* your scheduled visit. It is the patient's responsibility to make sure we have received authorization. If you do not have the proper authorization, your appointment will be rescheduled.
8. **SELF-PAY PATIENTS:** This category includes patients with no insurance and the patients who have an insurance plan with which we do not participate. Payment for medical services is required prior to services being rendered. We accept Visa, MasterCard, Discover and American Express, checks, cash, and money orders. A Good Faith Estimate and receipt will be provided.
9. Should you need to cancel or change your office visit appointment we require 24 hours notice or you may be subject to a **$25.00 charge**.
10. We understand that there may be times and circumstances that come up where you are unable to pay your entire bill. In these situations, it is very important that you contact our billing office at (318) 797-5848 option 4 so a financial representative can assist you in setting up a reasonable payment plan and to keep your account in good standing. The provider and/or practice manager must approve payment plans and discounts. Payment arrangements are understood and agreed upon by the patient and provider prior to services being rendered.

By signing below, I agree that I am financially responsible for any charges incurred for missed appointments in which I did not give the required advanced notice.

AS A FINAL NOTE:

Your policy is a contract between you and your insurance company. We are not a part of that contract and cannot guarantee payment by your insurance carrier. If your insurance plan does not pay for all services or denies coverage, you will be fully responsible for all contracted fees due. If your insurance company denies payment of your claim, contact your insurance company directly. If they have not paid you will be held entirely responsible for any balance due, and you will be billed accordingly. Dissatisfaction with your insurance company does not constitute reason to withhold payment of your account with RCIPS. We do accept assignment of your benefits; however, please be aware that some or all of the services provided may be a non-covered service under your plan. You will be responsible for these non-covered charges. In the event that your insurance coverage relates to a plan where we are not a participating provider, you will be 100% responsible for all charges incurred.

If you have any questions regarding this financial policy, please call BEFORE you are seen. Our business office is prepared to answer any questions you may have at (318) 797-5848 option 4.

My signature below verifies that I have read and understand the *Financial Policy* outlined above and that a copy of the policy is available to me upon my request.

Patient Signature Date Signed