

## FINANCIAL POLICY

Thank you for choosing Boice-Willis Clinic, PA. We are committed to providing you with quality health care. Please understand that payment of your bill is part of your care. To help avoid misunderstandings, we have provided you with details of our financial policy below. Please read it, ask us any questions you may have. A copy will be provided to you upon request.

**Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan, we do business with, payment in full is expected at each visit (at the self-pay rate with 30% pay now discount, same exclusions as self-pay guidelines apply). As our patient, it is your responsibility to verify prior to receiving services whether we are contracted with your payer or not. If you are insured by a plan, we do business with but do not have an up-to-date insurance card, payment in full (at the self-pay rate with 30% pay now discount, same exclusions as self-pay guidelines apply) for each visit may be required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**Co-payments.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company and therefore you are contractually obligated to pay this amount. Failure to collect co-payments and deductibles from patients is considered fraud. Please help us in upholding the law by paying your co-payment at each visit. We may also collect your co-insurance and/or deductible balance at the time of service.

**Payment.** We accept payment by cash, check, money order, VISA, MasterCard, Discover, or American Express in all locations. Some locations at Boice-Willis Clinic accept CareCredit as a payment method. We do accept on-line payments at our website at [www.boice-willis.com](http://www.boice-willis.com) (<https://www.boice-willis.com/>). All previous balances must be paid at time of service unless prior arrangements have been made. If a check is returned for insufficient funds or payment has been stopped, you will be charged a \$25 fee in addition to the amount of the check or credit card payment owed.

**Self-Pay.** Payment in full is due prior to rendering services from all uninsured patients unless any prior payment arrangements have been made. You will have 45 days to pay your balance in full. You will receive a 30% pay now discount if paying your entire balance at the time of service. (DOT physicals, sports, school, insurance, and work physicals, laboratory services, drugs, and cosmetic procedures are excluded from the discount). The balance is the best estimate and there could be additional charges after your visit. If you have paid in full on the date of service, you can still receive a 30% discount on the remaining balance.

**Minor patients.** The following parties are responsible for payment of all minor patient balances: the account holder or the parents (or guardians.) We do not recognize domestic judgments including custody agreements.

**Non-covered services.** Please be aware that some-and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. (The insurance rate will be charged without a 30% discount – No discount). You must pay for these services in full at the time of the visit. Please ask to speak with our billing staff if you need assistance regarding an extended payment schedule.

**Sports, school, and camp physicals** are not covered by many insurance companies. “Sports, school, and camp physicals” should not replace the annual well-child exam. We can complete a clearance form at the time of your child’s well-child exam. We recommend a sports physical be provided in the context of a full preventive visit.

**Proof of insurance.** All patients must complete our patient information form periodically prior to seeing the doctor. We must obtain a copy of your driver’s license, your current insurance card and in some cases your social security number to confirm proof of insurance and file your claim. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the entire balance of a claim. Additionally,

we must obtain the policyholder's date of birth and may require their social security number to file claims with your insurance carrier. We will file supplemental insurances when appropriate. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

**Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. You are expected to bring a copy of your new insurance card before or at the time of your next visit. If your insurance company does not pay your claim in a timely manner, the balance will be your responsibility.

**Nonpayment.** If your account becomes delinquent, you agree to pay any charges to collect your unpaid bills, including but not limited to, reasonable court costs, and/or collection agency fees. Accounts are considered past due when there is no payment activity for 45 days after the date of the first patient statement. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care.

**Referrals.** If you have insurance that requires a referral, you must have your referral prior to receiving treatment. It is your responsibility to obtain all necessary referrals from your primary care physician or insurance company or both, whichever is applicable. Patients without proper referrals who elect to receive service from the office will be required to make payments in full at the time of service.

**Worker's Compensation.** It is your responsibility to file a report with your employer. If you are injured on the job, please let the receptionist know so we may contact your employer to facilitate filing your claim. We will be happy to refund any money received from you once your worker's comp claim processes.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

**Signature**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Print Patient Name**

\_\_\_\_\_

**Date of Birth**

\_\_\_\_\_

**Account Number**

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For your convenience, the Clinic accepts MasterCard, VISA, American Express and Discover.

