Intracoastal Internal Medicine Financial Policy

Insurance:

You must present a current copy of your insurance card at each visit. We will file your claim if we are a participating provider of your insurance plan.

If we do not participate with your insurance carrier, you will be responsible for payment, in full, at the time of service.

All co-pays, deductibles and co-insurance are due at the time of check-in.

We must receive your billing information at each visit in order to meet claims submission guidelines set by your insurance plan. If either the practice or the plan fails to receive accurate information necessary to process your claim, you will be held responsible. We must have a copy of your current insurance card to file for you or your family member. If you do not have your insurance card, we will ask for payment in full at the time of visit.

In summary, your financial responsibility pertains to:

- Denied and non-covered services
- Services deemed not medically necessary by your insurance company
- Co-payments, deductibles, co-insurance
- Pending claims due to lack of patient and/or guarantor information or not updating Coordination of Benefits
- Non-insurance and/or out of network benefit
- Self-pay patients must pay in full at time of service

We will allow your insurance company 45 days to pay your insurance claim. If they have not paid by the 46th day, 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 IIM. 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.

We cannot waive amounts defined as patient responsibility as such waiver could violate State and Federal laws.

Lab and Other Diagnostic Testing Services – Lab Services and other diagnostic testing services are provided by independent medical providers, i.e., LabCorp. You will receive a separate bill directly from them for payment of their services provided. Please contact them directly with any questions regarding their bill.

Payment Options: We accept Visa, Mastercard, Discover, Debit, CareCredit, cash, and checks. If you do not have a Care Credit Account, please go to our website at intracoastalmedicine.com, and click on the CareCredit link for directions on how to apply for this payment option.

We accept electronic payments through our website secure on-line patient payment link at www.intracoastalmedicine.com "Pay My Bill".

A service charge of $25.00 will be applied to your account for all returned checks or any stopped payment on an issued check. There is a $25 fee for the completion of FMLA and Disability Forms completed by our office.

Collection Accounts: Any past due balances not paid will be turned over to a collection agency after 45 days unless payment arrangements have been made with IIM.

Refunds: IIM will issue refunds once all insurance claims have been paid and your account has a credit balance. Refunds will not be issued for amounts less than $10.00. Refunds are issued bi-weekly.

Missed Appointments: We require a 24-hour notice of cancellation for all appointments. If we don't receive at least 24 hours advance notice, we may charge you a $25.00 missed appointment fee. This charge will not be billed to your insurance company.

Authorization: I agree to be responsible for any medical expenses incurred with IIM, therefore, I authorize my insurance company, attorney, or other parties to pay directly to IIM, and/or provide any information regarding payment of my bill. I have read, understood, and agreed to the financial policy stated above and I accept responsibility for any balance not covered by my insurance company.

Patient Name: ____ **DOB:** _________________

Signature of Patient or Responsible Party:________________________________ **Date:** _____________