

Patient Financial Agreement



MARTIN'S POINT®
HEALTHCARE

We ask all Martin's Point Health Care patients (or their parent/legal guardian) to review and sign this financial agreement. This financial agreement outlines what your financial responsibilities are under the Martin's Point Health Care Billing policy.

As a patient (or parent/legal guardian), you are responsible for:

- ▶ Providing accurate and current insurance information—You are required to provide Martin's Point Health Care with valid insurance card(s) to provide proof of insurance. If you fail to provide us with correct insurance information or your insurance changes and you fail to notify us in a timely manner (within 30 days from the date of service), you may be responsible for the balance on the claim(s).
- ▶ Insurance eligibility verification—If we are unable to verify eligibility of the insurance from the information that you provide us, you will be considered a self-pay patient until we receive verifiable insurance information from you.
- ▶ Out-of-network insurance—We accept assignment and are in network with many, but not all, insurance plans. If Martin's Point Health Care is not in your insurance plan's network, you will be responsible for paying any amount that your insurance does not cover.
- ▶ Claims—We will submit your claims to your insurance and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from us and may need information from you. It is your responsibility to comply with your insurance and provide them with any and all information they request from you in a timely manner. If you fail to do so, you will be responsible for the charges.
- ▶ Copay—You are expected to pay your insurance copay at the time of service.
- ▶ Missed appointments—You are responsible for keeping all of your scheduled appointments. If you are unable to keep an appointment, you are expected to call us as soon as possible (2 hours in advance) to cancel the appointment. This allows us to offer your appointment time to another patient who may have an urgent need. Otherwise, it is possible that you will be billed for a no-show appointment.
- ▶ Uninsured patients—We offer a 20% prompt-pay discount to uninsured patients if the balance is paid within 30 days of the date of service. We will not apply the discount until the 80% is paid by you. To obtain this discount, you must call to make payment over the phone and we will apply the discount after payment is made. The prompt-pay discount does not apply

Administrative Offices

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to DME, pharmacy, medical supplies (including IUDs), foreign travel services, medication, radiology reading fees**, reference laboratory services** and vaccinations.

- ** Radiology & Reference labs: Martin’s Point uses external radiology groups and reference labs for some services. Patients may receive a separate bill from the radiology group and/or the reference lab in addition to those fees from Martin’s Point Health Care.
- ▶ Collections—If your account is more than 90 days past due (three statements sent to you without payment) your account may be sent to our collection agency. To avoid this, please pay your balance in full upon receipt of your first statement or call the billing department to set up a payment plan. We try to help patients avoid any balances from going to collections. Therefore, each month you will receive calls and/or emails from us reminding you of any due balances to try to help avoid collection activity.

Payment plan guidelines:

- \$0-\$100 3 months payment plan (full balance divided by 3)
 - \$101-\$250 6 months (full balance divided by 6)
 - \$251-\$1000 12 months (full balance divided by 12)
 - \$1000 or greater 18 months (full balance divided by 18)
- ▶ Failure to pay your balance—If your balance remains unpaid and reaches \$1000 (both collection agency balance and in-house balance) without payments, **we may disengage you from the practice.** We do all we can to help you avoid this as this is a last measure. To avoid disengagement, you are expected to pay your balances in full, apply and qualify for our financial assistance, or set up and maintain a reasonable payment plan.

I have read and understand the financial policy and agree to abide by its guidelines.

Signature: _____ Date _____

Print name: _____

Relationship to patient: Self Legal Guardian
 Mother Father