The Purcell Clinic PA

Patient Financial Policy

The Purcell Clinic understands that the cost of healthcare is a key concern for our patients. Although patient care is our main priority, we hope that you assist us by understanding your responsibility as it relates to our Financial Policy. If you have questions regarding our policy, a representative of our staff will be glad to assist you!

We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy:

FULL PAYMENT OF PATIENT OBLIGATIONS IS DUE AT TIME OF SERVICE

We accept cash, checks, credit, debit cards and credit card on file (which is an encrypted site for you to make payments). Effective November 1, 2014. If you do not pay your co-pay at the time of the visit we have an administrative fee of $10.00 that will be added to your bill. If you pay the co-pay within 7 days we will remove the administrative fee.

If your insurance has a high deductible you will be asked to pay $20 at time of registration even if you are on a payment plan. If you do not pay this amount then $10 will be added to your account as an administrative fee and if paid within 7 days we will adjust this off.

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do participate with your insurance please be aware that some, and perhaps all, of the services provided may be non-covered services under your plan and you will be 100% responsible for these charges. It is your responsibility to:

- Ensure that our physicians actively participate with your insurance company.
- Know your benefit coverage, as well as your dependents, prior to receiving services.
- Ensure that all pre-approval requirements are met to avoid denials or out of network benefits.

Please remember that we must receive your billing information at the time of ***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 to process your claim, you will be held responsible.

Regarding Insurance Plans where we are a participating provider (in network), all co- pays and deductibles are due at time of treatment. 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.

Your financial summary is summarized as follows:

- Denied and Non-covered services
- Services deemed not medically necessary by your insurance company
- Co-payments, deductibles, co-insurance
- Pended claims due to lack of patient and/or guarantor information
- Non- insurance and/or out of network benefits

If you fail to receive an Explanation of Benefits (EOB) from your insurance company within 45 days of treatment, we suggest you contact your insurance plan to determine why it has not paid. After 90 days we have the option of moving the charges for that visit to patient responsibility and you may be required to make other payment arrangements.

SELF PAY PATIENTS

In the event that you do not have insurance, the balance for the treatment that day is your responsibility and must be paid prior to services. Please discuss with the receptionists the plans we offer for patients that do not have insurance. The financial responsibility and other information contained in this form apply to all patients regardless of insurance status.

The Purcell Clinic does not involve itself in domestic issues. The person bringing the patient is responsible for the co-pay or deductible that day.

The Purcell Clinic reserves the right to send any unpaid balances to collections or small claims court. We send statements and will work with you on a payment plan. If we must file a claim in small claims court this office shall be entitled to the filing fee and/or court costs as part of the settlement.

Thank you for understanding our Financial Policy. Please let us know if you have questions.

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Please list your children:

First and Last name	Date of Birth:
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____
6._____	_____

I have agreed to this Financial Policy and I am the person who has the authority to sign:

_____ _____

Signature of Responsible Party Date