Compassionate Care
FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help by reducing the number of bills we send to you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. Compassionate Care accepts cash, personal checks (in-state only), VISA, and MasterCard. There is a service charge of $30 for returned checks.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. We realize that financial difficulty is a reality and we are here to work with you but you must keep us informed.

INSURANCE:
We bill participating insurance companies as a courtesy to you. You must bring a current insurance card for verification. If we cannot verify your insurance coverage, payment in full will be required at the time of your visit You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 90 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid by you or by your insurance carrier.

If you need assistance or have questions, please contact the billing coordinator between 9am and 5pm Monday-Thursday at (828) 832-8300.

MANAGED CARE:
If you are enrolled in a managed care insurance plan (i.e., HMO) you must receive a referral from our office before seeing a specialist. Retroactive referrals are not guaranteed.

MISSED APPOINTMENTS/LATE CANCELLATIONS:
Broken appointment represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested >24 hours prior to the appointment. A fee will be assessed for missed routine visits or if the appointment is cancelled <24 hours prior to the scheduled time at a rate of $20 for a routine visit and $50 for a complete physical exam. Excessive abuse or no shows of scheduled appointments may result in discharge from the practice.

I have read and understand Compassionate Care's Financial Policy. I agree to assign insurance benefits to Compassionate Care. I also agree that if it becomes necesssay to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or authorized representative: _____
Date: _____