Hypertension Nephrology Associates, PC

Financial Policy

1. **PAYMENT. PAYMENT IS EXPECTED AT THE TIME OF VISIT.** Payments and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service. **REFILL REQUESTS WILL BE DENIED UNTIL PAYMENT IS MADE ON OUTSTANDING BALANCES.**
2. **SELF-PAY.** Patients with no insurance are expected to pay for service in FULL at the time of the visit. **35% discount will apply to payments made in full at the time of service.** Your signature below indicates you are not eligible for Medicare, Medicaid or Tricare if you are a Self-Pay/Cash Pay patient.
3. **INSURANCE**. **IT IS YOUR RESPONSIBILITY TO KNOW YOUR BENEFITS.** If you have insurance we will send all claims to your insurance first. Please remember that we are a business providing a service. Our agreement to accept your insurance is a "value adding" service we provide to our customers. Your insurance is a contract between YOU and the insurance company. Payment will come from either you, your insurance, OR BOTH in the case of deductibles and copays; ultimately, you are responsible for payment. If your insurance company does not pay the practice within a reasonable, and contractually agreed upon time, you may be billed for the services we provided to you. If we later receive payment from your insurance we will refund you any overpayment. If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. **Many web sites have erroneous information and are NOT a guarantee of coverage. If you have insurance and fail, or refuse, to provide us a copy of the physical card, or the information on your card, we may not be able to confirm benefits. In this case, you are responsible for payment of services. We will be bill you directly.**
4. **REFERRALS.** Certain health insurances (HMO, PPOs, etc.) require that you obtain a referral from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral, you are responsible for obtaining it. Alternative payment arrangements or rescheduling your appointment may be necessary if not obtained.
5. **ADDITIONAL FEES**
    1. **RETURNED CHECKS** will incur a **$35.00** service charge. You will be asked to bring in cash, certified fund, money order, or credit card to cover the amount of the check plus the $35 service charge.
    2. **LATE FEES.** Late fees will be added to past due balances.
    3. **COLLECTION FEES.** A fee of $10.00 will be added to all balances forwarded to collections. In addition, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the account balance, and all costs and expenses, including reasonable attorney's fees, we incur in such collection efforts.
    4. **MISSED APPOINTMENTS.** From the moment you schedule your appointment we incur costs to provide care to you as a customer. A $20.00 charge is applied to your account for missed appointments (aka, "No Show").
    5. **FORM FEES.** There may be a fee charged for the completion of forms (example: Family Medical Leave Act forms).
    6. **MEDICAL RECORD COPIES.** We charge for copies of medical records; Rates are based on Michigan state law, Medical Records Access Act 47 of 2004, 333.23269 Section 9. HNA reserves the right to change rates without notice to outside parties within compliance of the law.
6. **RELEASE OF INFORMATION.** I hereby authorize and direct Hypertension Nephrology Associates, PC to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.
7. **REFUNDS.** In the event of an overpayment to our practice, your claim will be investigated and a refund will be issued accordingly.

I have read and understand the practice's financial policy, and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time-to-time.

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Signature of Patient (or Guarantor, if applicable) Date

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Please print the name of the patient