Reinhart Family Healthcare

Financial Policy

In order for our office to deliver the quality of care that you are accustomed to, we have established financial policies.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. We ask that you present your insurance card(s) at each visit. It is your responsibility to provide us the correct information to bill your insurance.
2. If you have a change of address, telephone numbers, or employer, please notify the receptionist.
3. We will collect your co-payment, charges from previous visits, and charges for non-covered services at the time of your visit. We accept cash, checks, and Visa, MasterCard, Discover, AMEX and debitcards.
4. Your account will be charged a fee for returned checks for non-sufficientfunds.
5. By Federal Law and Managed Care Contract law, this office is required to collect co-payments at the time of service. If you do not pay your co-payment you will be charged a delinquent co-paymentfee.
6. If your insurance denies our charges or does not pay us in a timely manner, you will be responsible for the charges.
7. If your account becomes delinquent we reserve the right to refer your account to a collection agency and report it to a credit bureau.
8. MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all of your covered charges. We will also bill any secondary insurance you may have. If you do not have a secondary insurance, any remaining balance will be your responsibility. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
9. HMO-PPO PATIENTS: If we participate with your plan, we will bill your insurance for you. If your plan requires you to choose a primary care physician, it is your responsibility to notify your plan. If your plan requires you to have an authorization to see a specialist you will need to obtain that from our office prior to seeing the specialist. No retroactive referrals will be given. If we do not participate with your plan, we will attempt to bill your insurance. Any amount remaining from your out-of-network benefits will be your responsibility to pay.
10. SELF-PAY PATIENTS: Patients with no insurance will be expected to pay at the time of service. If you are not able to pay in full, you will need to contact our billing department to discuss payment arrangements prior to being seen.
11. MEDICAID PATIENTS: We are contracted with traditional Medicaid and some Medicaid HMO plans. If we are contracted with your plan we will submit your claims. If we are not contracted with your plan we will not submit your claim and you will be considered self-pay and are liable for payment of all services provided. Services may be a covered Medicaid service and other providers may render the service at no cost to you. In the future if you choose to utilize your Medicaid plan you agree to transfer care to a Medicaid provider. Patients that miss an appointment will be discharged from the practice.
12. When an appointment is scheduled that time is specifically allocated for you. When an appointment is not canceled in advance we consider this a “no show”. We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment at least two hours ahead. If two appointments are missed without cancellation, you

may be charged a fee.

13. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. It is very important that you understand the provisions in your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, this becomes your financial obligation.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department at 479-968-4273.

By signing below, you are attesting that you have read and have a full understanding of the financial policy of Reinhart Family Healthcare.

Printed Name:_____ Date of Birth: _____

Signature/Legal Guardian:_____ Date: _____