Town Clinic of Crested Butte, PLLC

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Payment Policy for Town Clinic of Crested Butte, PLLC

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. We have developed this payment policy to explain your patient and insurance responsibility for services rendered by our office. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request; it is also available on our website.

1. Insurance. We participate in a select number of insurance plans at this time. If you are not insured by a plan we do business with, payment in full is expected at each visit. We have some alternatives available to decrease upfront cost and you may submit a claim to your insurance company for reimbursement. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service as they are your responsibility as the insured. This arrangement is part of your contract with your insurance company. *Failure on our part to collect co-payments and deductibles from patients is considered fraud*. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit, if after submitting to your insurance company they deny any charges and/or deem them as covered; these charges will be billed to you directly.

4. Proof of insurance. All patients must complete our patient registration form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. If we are in-network with your insurance company, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. If we are out of network for your insurance company, we will generate the claim for you, but it is your responsibility to file the claim. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not privy to that contract.

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6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within 24 hours unless extenuating circumstances are communicated to our office. If our office is not notified within this time frame then you will be charged $50.00 for the missed appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

9. Insufficient Funds. If a check is returned for insufficient funds or any other reason our office will send you a notification letter and you will be charged $25.00 in addition to any existing balance. Please make every effort to use active accounts with sufficient funds to avoid any penalties.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

_____

Print name

Thank you!!