CobbWest
Internal Medicine Associates

PRACTICE FINANCIAL POLICY

Thank you for choosing Cobbwest Internal Medicine. We are committed to providing you with quality health care. Please understand that payment of your bill is part of your care. To help avoid misunderstandings. We have provided you with details of our financial policy below.

Insurance: We participate with most insurance plans, Including Medicare. If you are not insured by a plan we accept, payment in full is expected at each visit. If we do accept your plan, but you do not have current insurance card, payment in full for each visit is required until we verify coverage. Knowing your insurance benefits plan is your responsibility. It is your responsibility to make sure the correct in – network facility is used for all test and hospital encounters. Please contact your insurance company with any questions you my have regarding your coverage.

A coordination of benefits form (COB) must be filled out annually and sent to your insurance company letting them know whether or not you have additional coverage. Failure to return this information to your insurance company will be responsible for all charges

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

Self-Pay. A minimum $100.00 payment for existing patients and $160.00 for new patients is due prior to treatment from all uninsured patients. You will have 60 days to pay your balance in full. A full Physical can be done which includes certain labs call the office for details at an additional cost.

Proof of insurance. All patients must complete our patient information form periodically prior to seeing the doctor. We must obtain a copy of your driver's license, your current insurance card and your social security number in order to confirm proof of insurance and file your claim. 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.

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 a timely manner, the balance will be your responsibility.

Nonpayment. If your account becomes delinquent, you agree to pay any charges to collect your unpaid bills, including but not limited to, reasonable court costs, and/or collection agency fees. After you have received two statements, your account is considered past due. At that time, you will receive a letter stating that you now have 10 days to pay your account in full. Payment plans may not exceed a six month time period, unless otherwise negotiated. You must contact us for a reasonable payment arrangement or risk collection action. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency or a collection attorney and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Co-payments. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure 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.

Payment. We accept payment by cash, check, VISA, MasterCard, Discover or American Express. All previous balances must be paid at time of service, unless prior arrangements have been made with the billing department. If a check is returned for insufficient funds or payment has been stopped, you will be charged a $35 fee in addition to the amount of the check. If you have a second check returned, you will be asked to pay by cash, money order, cashier's check, or credit card for future visits.

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.

PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING. By signing below, I acknowledge that I have read and understand this policy.

_____ _____

Signature of Patient and/or Responsible party **Date**