

## FINANCIAL POLICIES

Thank you for choosing the Diabetes and Metabolism Specialists of San Antonio for your endocrine care. This document describes the practice financial policy and we ask that you review it carefully and ask any questions that you may have prior to treatment.

Because health care benefits and coverage options have become increasingly complex we have developed this financial policy to help you to better understand your responsibilities as a patient. We will do our best to assist you with understanding your proposed treatment and in answering questions related to submitting your insurance claim for reimbursement.

### **INSURANCE COVERAGE:**

We will bill insurance carriers for you and collect their portion as a courtesy to you.

You are ultimately responsible for all professional fees regardless of your insurance coverage status. Once insurance has processed your claim you will receive a monthly bill indicating an outstanding balance on your account.

It is your responsibility to know if your insurance has specific rules or regulations such as the need for referrals, pre-certifications, prior authorizations, limits on out-patient coverage and any requirements for specific physicians, labs or hospitals to use. Please understand that your insurance **MAY NOT COVER** some services or procedures and that if your insurance carrier does not cover the service or procedure you are responsible for all charges.

**PLEASE NOTE** that your health insurance policy is a contract between you and your health insurance company or your employer. Your doctor bill is an agreement between you and your doctor.

Please provide us with your current insurance plan information at the time of your appointment and notify us of any changes at each visit. We will require a copy of your insurance card to copy for our records.

Please be aware of and provide any required referrals or authorizations in advance of the appointment or service. If you do not provide these before care is provided you will be responsible for the cost of the care or service.

Before your appointment please be sure that your doctor is in-network and the services are covered by your plan. If the doctor is out-of-network you will be billed for the costs of the care. We will help you find out if you have out-of-network benefits and we will submit a claim to your plan on your behalf. Please refer to our out-of-network policy below for more details.

Please let us know at any time if you do not want us to submit a claim on your behalf.

**ADDRESS CHANGE:**

It is important that we have your correct address information on file. Please advise us any time there is a change to your address, telephone or other contact information.

**CO-PAYMENTS/CO-INSURANCE/DEDUCTIBLES:**

You are expected to pay your co-payment and any co-insurance and/or deductibles at the time of your.

**NON-MEDICAL FEES:**

Additional fees may apply to the following:

Returned Checks

Completion of Disability, FMLA and other forms

Copying of medical records

**PAYMENTS:**

Payment is due at the time the services are provided or upon receipt of a statement from our billing office. We accept payment in the form of cash, check, money order or credit card (Visa, MasterCard, and Discover). Returned checks are subject to a fee. We do not accept travelers checks.

**MISSED APPOINTMENTS:**

We require a 24 hour cancellation notice. If you miss your appointment or do not cancel with the required notice, additional fees may apply:

Office Visit \$75

Second Missed Office Visit \$100

New Patient Visit \$100

Office Procedure \$100

**OUT-OF-NETWORK PROVIDERS:**

If the doctor is not in your insurance plan, the following apply:

You will be quoted an estimated fee before services/procedures are performed.

After your appointment we will submit a claim to your plan for services performed.

You are ultimately responsible for all professional fees regardless of your insurance coverage status.

Once insurance has processed your claim you will receive a monthly bill indicating an outstanding balance on your account.

Depending on your plan payment may be sent to you. If you receive this payment you agree to reimburse Diabetes and Metabolism Specialists immediately.

**SELF-PAY PATIENTS:**

Full payment is expected at the time of service for all visits.

**NON-COVERED SERVICES:**

**Medicare Patients** Medicare may not cover some services that your doctor recommends. You will be informed ahead of time that this may be the case and will be given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing that you are responsible for payment. You must read the ABN carefully.

**Non-Medicare Patients** Any service not covered by your plan is your responsibility and must be paid in full at the time of service or upon receiving a bill for the services.

**PAYMENT PLANS:**

We understand that medical care can become expensive. If you have concerns about your ability to pay you can contact us for help in managing your account.

**REFUNDS:**

A refund is issued when an overpayment has been identified. If you feel that a refund is due please contact our billing office at 210.982.0078.

**FAILURE TO PAY:**

If you do not pay your bill your account will be sent to an outside collection agency. If your account is sent to a collection agency you will need to contact them directly to settle your account balances.

**POLICY AND FEE CHANGES:**

The policies and fees are subject to change. We will do our best to keep you informed of any modifications. Current policies can be obtained by visiting our website at:

[www.diabetesandmetabolism.com](http://www.diabetesandmetabolism.com)

For any questions about these policies please speak to the office manager or billing office at 210.982.0078.

**CREDIT CARD CONSENT FORM:**

Our practice requires all patients have a credit card on file for missed appointments. We also require a 24-hour cancellation notice.

**ACKNOWLEDGEMENT:**

I have read and understand these Financial Policies and I agree to be bound by the terms of these Policies in making payment for medical services provided to me by the Diabetes and Metabolism Specialists of San Antonio.

I hereby authorize payment to be made directly to the physician for services provided to me. I understand that I am financially obligated for charges not covered by this authorization. I authorize the release of my information to physician, provider or third party payor (insurance company) in order to process payment.

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Signature

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Date

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Print Name