CAROLINE R. PRICE M.D., P.A.

10 Enterprise Boulevard, Suite 207
Greenville, South Carolina 29615
864-331-2505 telephone
864-331-2510 facsimile

FINANCIAL POLICY

Please read this financial policy carefully. If you have any questions about this policy, a member of our staff will be glad to assist you.

1. **PAYMENT FOR SERVICES: Payment, including but not limited to co-payment, coinsurance, and deductible, is due at time of service. Patient and/or guarantor is financially responsible for payment of all services rendered.**

   Our office will file medical claims to a patient's health insurance company. We require presentation of a valid health insurance card and accurate demographic information to properly file these claims.

   If our practice is not contracted with a managed care plan the patient is under, the patient and/or guarantor will be responsible for payment at the time the service is rendered.

   Certain health plans will only pay for healthcare services that are deemed medically necessary and are considered "covered services" as defined in the Certificate of Coverage, which is issued to every enrolled beneficiary. Patient and/or guarantor is also responsible for payment of any "non-covered" service.

   A patient's insurance company may require additional information from the patient before they process the claim. Please respond promptly to their requests. Failure to respond to this request may result in a denial of payment by the insurance, subsequently all charges may become the financial responsibility of the patient and/or guarantor.

   Cosmetic consultations and/or procedures are not submitted for insurance claim; payment must be made prior to services rendered.

   MEDICARE: Caroline R. Price, MD is a non-participating Medicare Provider; therefore, payment is expected at the time of service. We will file the claim with Medicare as well as any supplemental plan to help expedite reimbursement.

   MEDICAID: Caroline R. Price, MD is a non-participating Medicaid provider. Patients with Medicaid can be seen on a self-pay basis; payment in full is expected at time of service.

   HMOS: Patients with HMO insurance must obtain a referral from a primary care physician prior to the scheduled appointment. If the necessary documentation has not been received, the appointment will be rescheduled.

2. **METHODS OF PAYMENT**: Payment for services can be made with cash, check, or credit card **(Visa, Discover and MasterCard accepted)**.

3. **RETURNED CHECKS**: A **$30.00** service charge will be added by our office to a patient's account for each returned check.

4. **COLLECTION POLICY**: Accounts that are unpaid for ninety (90) days after the initial billing date will be considered delinquent. Delinquent accounts will be charged 1.5% per month (18% percent interest per annum) accruing from the date the services are rendered until the date the account is satisfied. Accounts unpaid after 90 days from the initial billing date may also be forwarded to a Credit Reporting Agency. The patient and/or guarantor will be responsible for court costs as well as reasonable attorney fees that are incurred to collect debts.

5. **APPOINTMENT TIME**: We request **24 hours notice** for appointment cancellation. Appointments that are not cancelled may result in a standard "no show" charge of **$25.00 ($50.00 for office procedures and/or surgeries)**. Anyone arriving 15 minutes late or more for an appointment may be asked to reschedule. These additional charges are the full responsibility of the patient and/or guarantor; these fees will not be filed to an insurance company.

6. **NON-APPOINTMENT PRESCRIPTION REFILLS**: A **$15.00 service charge** per incidence may be added for all non-appointment prescription refills. Once payment is received will we gladly call in the prescription to your pharmacy or it will be available for pick up at our office.

7. **QUESTIONS**: We are here to help should you have any questions regarding your statement or insurance.

I have read, understand, and agree to the above Financial Policy. I also understand and agree that the terms of the Financial Policy may be amended from time to time. Regardless of my insurance status, I am ultimately responsible for payment of any professional service rendered.

____
Patient/Guardian Legal Name (Please Print)

____ **Today's Date: _____/_____/_____**
Patient/Guardian Signature