

**LINTECUM & NICKELL, P.C.**  
**OFFICE AND FINANCIAL POLICY**

**EFFECTIVE 1/1/2019**

Patient Name: \_\_\_\_\_ Patient number: \_\_\_\_\_

All patients must complete our Financial Policy and Patient Information forms **prior** to seeing the physician.

**PLEASE NOTE: All appointment times are guidelines only. The physicians will spend as much time as needed to meet each patient's individual needs. This, as well as emergency cases and deliveries, can result in a delay in the daily schedules. We ask for your patience.**

**If you are more than 10 minutes late for your scheduled appointment time we reserve the right to not see you and reschedule your appointment.**

**YOUR INSURANCE INFORMATION AND PAYMENT RESPONSIBILITY:** Please have your **current** Insurance ID card available at each visit as well as a photo ID and current active credit card. We reserve the right to not see you if this information is not provided. It is your responsibility to inform our office of any changes.

The cost of medical care is determined by the nature and complexity of your visit. If you are here for an annual or wellness exam and problems are addressed then additional charges may apply or another scheduled visit may be needed. **NON-emergent** phone calls after hours may also result in a charge.

Your insurance plan is a contract between you and your insurance company. **As a service to you**, our office makes every effort to obtain payment according to your coverage. It is the responsibility of you the patient to know and understand your insurance benefits as well as network status of your plan with our office. Payment for services rendered is the responsibility of the patient whether your insurance pays or not. Our office also attempts to obtain accurate information from your insurance company for some procedures. If your insurance company does not provide accurate information and subsequently does not pay for services it is the responsibility of the patient to follow up with your insurance company regarding the unpaid claim. You, the patient, will ultimately be responsible for payment.

**CO-PAYS, DEDUCTIBLES, CO-INSURANCE AND OUTSTANDING BALANCES:** All co-payments are due at the time of check-in, prior to your appointment with the doctor. By law we are required to make reasonable efforts to collect deductibles, and co-insurance and/or co-payment obligations. In addition, by law, we are responsible to attempt collections of these amounts once they are identified to us on your explanation of benefits as patient responsibility. This policy is in accordance with the legal requirements for collecting patient responsibility amounts. All patient responsibility amounts are due 30 days from the date of the statement which will be sent to you after the insurance has adjudicated the claim. Any unresolved outstanding balances may be placed with an outside collection agency. If this occurs you, the patient, will be additionally responsible for all collection agency fees, court costs and reasonable attorney fees.

**COLLECTIONS POLICY:** If you or your minor child is turned over to our collection agency; you have **90 days** to set up a payment plan or clear your balance at the agency in full. If you have not set up a payment plan with the agency by 90 days, you will receive a notice of dismissal as a patient from our practice.

**BANKRUPTCY POLICY:** If Lintecum & Nickell, P.C. receives a notification of bankruptcy proceedings, and our charges have been included in your bankruptcy proceedings, you will receive a letter of discharge from our practice. Federal law states that you are unable to accrue charges, including medical expenses during this time, unless it is medically necessary.

**PAYMENTS:** We accept cash, personal checks, VISA, MASTERCARD, and DISCOVER. Please refrain from bringing bills larger than \$20.00 as we are not a bank and do not have a large amount of cash in our office. Payment plans can be set up with our staff at the front desk.

**RETURNED CHECKS:** There is a \$20.00 fee for all returned checks.

**FORMS:** There is a \$25.00 fee for any forms that need to be filled out for you or your insurance company. Examples include FMLA and disability forms.

**RELEASE OF MEDICAL RECORDS:** Requests for release of medical records require written authorization by the patient. Authorization is not needed for requests from insurance companies, Federal agencies, or other medical professionals involved in the care of the patient. A fee is associated with all other records requests and must be paid prior to their release.

**CREDIT CARD ON FILE:** Lintecum & Nickell, P.C. requires a credit card to be placed on file for any and all balances that are over 30 days aged from the date of the current billing statement. These amounts will be placed on your card if payment has not been made or other payment arrangements have not been established with our practice within the 30 day window. This charge will occur with or without notification.

**MISSED APPOINTMENTS:** Any appointment that is not kept will be considered a "no show". The time that was reserved for you, prevented another patient from receiving our service. For this reason a \$25.00 fee will be charged for the unused appointment time and will be billed directly to the patient or guardian. Three "no shows" will result in dismissal from the practice.

**AUTHORIZATION:** I agree to abide by the terms of the above financial policy and accept responsibility for any balance not covered by my insurance company; therefore, I authorize my insurance company to pay directly to Lintecum & Nickell, P.C., and/or provide any information regarding payment of my bill. If my account becomes delinquent, I agree to pay all costs incurred in collecting the account, include collection agency fees, court costs and reasonable attorney's fee.

I authorize the physicians of Lintecum & Nickell, P.C. to administer care as necessary, including release of records or medical reports on my physical condition to any party involved in my treatment.

By signing below, I acknowledge and understand my financial responsibilities as a patient of Lintecum & Nickell, P.C.

\_\_\_\_\_  
Signature of patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Staff Member

\_\_\_\_\_  
Date