

Financial Policy Physician Offices

Patient: _____

Date of Birth: _____

Insurance

We will bill your insurance carrier according to our contract or as a courtesy to you; however payments for deductibles and copays are due at the time of service. This includes all office visits, procedures and injections. If you do not have your copay with you, your appointment may be rescheduled. Please remember that your insurance coverage is a contract between you and your insurance company and not a substitute for payment. Failure to provide us with your Social Security number may make it impossible for us to speak to your insurance regarding your claim.

Prior Authorizations

Some insurance plans require prior authorization for procedures done in the office. It is the patient's responsibility to check with their insurance prior to their visit to avoid possible higher deductible and copay charges.

Self-Pay Accounts/Plans We Don't Participate With

Self-pay accounts are patients who have no insurance coverage, have not met their deductible or are covered by insurance plans we do not participate with. Payment must be made at the time of service. If this is not possible, please discuss the situation with the billing department before your scheduled appointment.

No-show/Cancellation Policy

We ask that you provide 24-hours' notice if you are unable to keep a scheduled appointment. Failure to do so may result in a "No Show" fee charged to your account. Payment of this fee will be required prior to the rescheduling of a new appointment. Multiple missed appointments may result in discharge from our practice. Exceptions will be made on a case by case basis. Thank you in advance for your cooperation.

Collections

In the unlikely event that we require the services of a collection agency, a 25% surcharge will be added to your account.

Payment Methods

For your convenience, we accept the following methods of payment: Cash, Personal Check, Visa, MasterCard, Discover.

Authorization and Release

I, _____, authorize payment of medical benefits be made directly to Holland Hospital or its related entities. I understand the financial policy and accept the personal responsibility for payment of covered and non-covered services. I authorize the release of any medical or other information necessary to process my claims.

Patient/Guardian Signature: _____ Date: _____

Medicare Information/Authorization for Medicare Recipients

Number: _____ Primary? Yes No Medicare Part B?
 Yes No

I request that payment of authorized Medicare benefits be made to Holland Hospital or its related entities. I authorize any holder of medical information about me, needed to determine those benefits or the benefits payable for related services, to be released to the Centers for Medicare and Medicaid Services or its agents. I also authorize Medicare to send Explanation of Medicare Benefits information to my Medicare supplement and benefits to be paid to Holland Hospital or its related entities for any services furnished to me until further notice. I authorize any holder of information about me, needed to determine those benefits or the benefits payable for related services, to be released to the Centers for Medicare and Medicaid Services, or its agents.

Signature: _____ Date: _____