Patient's Name:_____ Date: ___/___/___

Patient Financial Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. The following is a statement of our payment policy. This payment policy applies to all services provided by Nephrology Associates, regardless of the location.

Insurance Coverage - We will bill your health insurance carrier for services rendered by our providers, but it is your responsibility to make sure that we have your most current insurance information. If you change or add an insurance policy, you must make our staff aware and present a new insurance card prior to your appointment. Any balances not paid by your insurance carrier are your responsibility, and payment is due upon receipt of a "Billing Statement" or your next office visit, whichever occurs first.

Referrals - If your insurance plan requires a referral, it is your responsibility to obtain one from your primary care physician. A referral should be requested from your primary care physician's office at least 48-72 hours prior to your appointment.

Copays - We have a contractual obligation (with your insurance company) to collect your copay. We will collect it at the time of service. **Our office does not bill copays. Copays are the patient's responsibility and are due at the time of service**. We are considered specialty care by insurance carriers. If your insurance carrier has a specific copay amount for specialty care, you will be expected to pay this amount at the time of service. We **cannot** waive copays, deductibles, or coinsurance for non-covered services defined as patient responsibility under the terms of our contract with various health plans.

For our patients with no Medical Insurance Benefits

If you do not have group or individual medical insurance, payment for all services is expected at the time of your visit. If you pay the charges in full on the day of service, we will offer a 5% prompt pay discount. Partial payments or payments made after the date of service are not subject to the prompt pay discount. Please let us know if you are having difficulty paying your account. Nephrology Associates may be able to help by setting up a payment plan based on your financial needs. Our billing office is available Monday – Friday from 8:00 a.m. to 4:30 p.m. to assist you in satisfying your financial obligation. Please contact our billing department directly at **(302) 225-0462** to discuss payment plans, patient financial evaluations and discounts available.

Accepted Forms of Payment - We accept payment by cash, check, Visa and Mastercard.

Unpaid Accounts - In the event that you do not satisfy your account balance on a timely basis (defined as making a regular payment each month), we may elect to send your account to an outside collection agency.

Other Possible Fees -

Missed Appointment Fee - A missed appointment is a scheduled appointment that you miss without notifying us in advance. A $20 fee will be billed for patients who do not show for a scheduled appointment. Our practice requests that you provide us with at least a 24 hour notice to cancel your appointment to avoid this charge. Insurance companies do not cover this charge. **Disclaimer:** The missed appointment fee will not be charged if you missed your appointment because you were an inpatient in the hospital.

Returned Check Fee - It is the policy of Nephrology Associates to charge $20.00 to patients whose checks are returned by our bank for non-sufficient funds.

I have read and agree to the above Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copay and deductibles are my responsibility.

_____ _____

Signature of Patient or Responsible Party if a Minor Date

_____

Please Print the Name of the Patient

MEDICARE EXTENDED AUTHORIZATION – "SIGNATURE ON FILE": I request that payment of authorized Medicare benefits be made either to me or, on my behalf, to Nephrology Associates, P.A. for any services furnished to me by members of that professional association. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or benefits payable for related services.

Signed _____ Date _____

COMMERCIAL INSURANCE ASSIGNMENT OF BENEFITS: I request that payment of authorized Commercial Insurance benefits, both primary and secondary, be made on my behalf to Nephrology Associates, P.A., for any services furnished to me by members of that professional association. I authorize any holder of medical information about me to release to the above-mentioned insurance carrier, any information needed to determine these benefits payable or benefits payable for related services.

Signed _____ Date _____