Barbara Plucknett, M.D., P.C.
Financial Policy

Welcome, Dr. Barbara Plucknett and her staff are happy to provide you with quality services and care, we hope you find our staff friendly and helpful.

All patients must complete our Financial Policy, Patient Information, Health Information, Policy and Coverage forms before seeing the doctor.

Your Insurance Information and Payment Responsibility: Please have your current insurance ID card available at each visit. If at any time your insurance should change, our office must be notified immediately of the change to accurately file claims.

The cost of medical care is determined by the nature and complexity of your illness or the reason for your visit. There is no "flat rate" for examinations and treatment. Your insurance plan is a contract between you and your insurance company. As a service to you, our office makes every reasonable effort to obtain payment according to your coverage. Payment for treatment you receive from Dr. Plucknett is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, and assign your benefits to Dr. Barbara Plucknett and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account or require that you make other payment arrangements regarding any amounts assigned as your responsibility by your insurance carrier. While we will use reasonable efforts to ensure that your insurance carrier properly processes your services for payment, the obligation to enforce the terms of your benefit contract is your responsibility. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, any balance remaining will be due and payable immediately. **It is, at all times your responsibility to follow up on all requests from your insurance company regarding claims and to question your insurance company about any unpaid claims.**

*Failure to provide the necessary referrals and / or authorizations will result in all charges for services becoming the sole responsibility of the patient / responsible party.

Usual and Customary Fees: Our practice is committed to providing the best treatment for our patients and we charge what we reasonably believe to be usual and customary based on a number of factors. Our fees are generally considered to fall within the acceptable range by most companies and the charge for each service is determined based on the relative value (RVU) of the service as published by the Center of MEdicare / Medicaid Services (CMS). Not all carriers utilize CMS RVU's when determining their allowances for a service. Many carriers implement an arbitrary schedule of allowances. Notwithstanding any contractual provision to the contrary between Dr. Barbara Plucknett and your health insurance carrier, Dr. Barbara Plucknett will accept your carrier's fee schedule allowance as a deductible obligation assigned by your carrier within 60 days of the date of the carrier's determination as expressed on your explanation of benefits. This statement does not mean that we accept the carrier's payment in full. **Your carrier generally only pays a portion or percentage of the allowed fee for a particular**

service in accordance with the terms of your benefit plan. Deductible, co-insurance and / or co-payment amounts are your responsibility. Where payment of amounts assigned to you by your insurance carrier is not made within 60 days of your carrier's determination, the amounts in excess of your insurance carrier's fee schedule allowance will be due and payable. **Where a service is not covered under your benefit plan, you will be responsible for the fee charged for such services.** Additionally, we reserve the right to appeal your carrier's determination regarding the amount allowed for any service we provide where the amount allowed is less than the amount charged. The amount you may be responsible for could therefore change depending on the outcome of such an appeal.

Co-pays, Deductibles, Co-insurance and Outstanding Balances: All co-payments, co-insurance and / or co-payments and deductible amounts are required to be paid under the terms of your contract with your insurance carrier and they are due and payable at the time of check-in, prior to your appointment with the Physician or Practitioner. 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. This [policy is in accordance with the legal requirements for collecting patient responsibility amounts. All charges are due and payable 60 days from the date of service. Unresolved outstanding balances may be placed with an outside collection agency and may also be subject to finance charges, attorney fees and collection agency fees.

Our practice accepts cash, personal checks (in-state only), VISA, Mastercard and Discover. We deliver the finest care at the most reasonable cost to our patients, therefore, payment is due at the time the service is rendered unless prior payment arrangements have been made. In most cases your insurance plan requires you to make a co-payment at your visit. We will ask for your co-payment upon check-in. If you are unable to pay your co-payment we may ask that you reschedule your appointment.

*** A $25.00 service charge will be applied to your account for all returned checks.**

Non-Covered Services: Your care may involve services that are not covered under your health benefit plan. You have the right to deny receipt of these services. **If you elect to receive a non-covered service that is recommended or necessary to your care, you will be fully responsible for payment of these services.** Where circumstances permit, we will attempt to verify the limitations of your health insurance benefit plan recognizing that you have the ultimate responsibility for knowing and understanding the coverage limitations of your insurance benefit contract. As the information we receive is not a guarantee of coverage or benefits, we cannot be responsible for the validity of the information supplied to us by your carrier. You are responsible to verify your coverage limitations based on your benefit contract.

Adult Patient: Adult patients are responsible for full payment at the time of service unless we are accepting assignment for insurance. For patients without insurance coverage, you agree to be responsible in full for all services provided in accordance with our negotiated fee schedule.

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Minor Patient: The adult accompanying a minor and the parents (or guardian of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless patient responsibility has been paid in advance for treatment, via credit card, check, or cash.

Self-Pay: Self-pay individuals will be expected to pay in full at the time of services.

Cancellations and Missed Appointments: unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $50.00. Please help us serve you better by keeping scheduled appointments. Further, understand that non-compliance with your ordered treatment plan may negate our ability to represent your services as medically necessary to your insurance carrier. This is to remind you that in order for the services performed at Dr. Barbara Plucknett, to be billed to your insurance carrier, those services must be considered to be medically necessary. Part of satisfying the medical necessity requirement is for Dr. Barbara Plucknett to develop a treatment program specific for your individual healthcare needs. Non-compliance with your treatment plan may interfere with our ability to make the progress that is required by your carrier to establish the medical necessity of the services such that they become covered by your insurance plan. If you are non-compliant with your ordered treatment plan you may be discharged from that plan.

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, attorney or other parties to pay directly to Dr. Barbara Plucknett 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, including a reasonable attorney's fee.

I authorize the physician in charge (Dr. Barbara Plucknett) to administer medical care as is necessary, including allowing 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. I authorize payment in full via my credit card by my signature below for any and all payments due today and in future dates of services for consultation, evaluation and procedures performed. (Please keep your credit card information updated).

_____ _____

Signature of Patient or Responsible Party/Guardian Date

_____ _____

Signature of Staff Witness Date

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Release of Information - HIPAA PRIVACY

Dr. Barbara Plucknett is concerned about the privacy of your individually identifiable health information and has enacted policies and procedures to protect your privacy as required by the Health Insurance Portability and Accountability Act of 1996. A notice of this practice's privacy practices can be obtained from a staff member.

I acknowledge that I have received the Notice of Privacy Practices for protected health information.

Date:_____

_____
Print Name

_____
Signature of Patient/Personal Representative