DELMARVA KIDNEY & HYPERTENSION SPECIALISTS LLC

Payment Policy

Thank you for choosing Delmarva Kidney & Hypertension Specialists for your healthcare. We are committed to the success of your medical care. Please understand that payment of your bill is a part of your care. Please ask our staff if you have any questions about our fees, financial policy or your responsibility. Delmarva Kidney & Hypertension Specialists strives to ensure a clear understanding of your financial responsibility with respect to the medical services we provide. The following policies pertain to all services rendered.

.

Co-Pays: All office co-pays are to be paid at the time of service. **This arrangement is part of your contract with your insurance company.** Failure on our part to collect co-pays and deductibles from patients can be considered fraud. We are considered Specialty Care by insurance carriers. We accept cash, checks or credit cards. We reserve the right to refuse treatment if co-pays are not paid.

Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, you may be responsible for the balance of your claim.

No Insurance: If you have no insurance, we collect the total amount of the visit, prior to the visit, providing you with a 20% discount off our charges.

Medicare: If you have Regular Medicare, and have not met your $166.00 Deductible, we expect it to be paid at the time of service. Any services not covered by Medicare will be your responsibility. If you have Medicare as primary, and also have secondary insurance (Medigap); No payment is necessary at the time of this visit. If you have Medicare, as primary, but no secondary insurance: Payment of 20% is expected at the time of the visit. We will file an insurance claim as a courtesy to you.

Insurance Claims: We will submit insurance claims for our patients. However, the agreement of the insurance carrier to pay for medical care is a contract between **you** and the **carrier**. You should direct any questions and/or complaints regarding coverage to your insurance carrier, your employer (if in a group plan), or to your agent.

Insurances vary in their coverage, and it is the **patient's responsibility** to understand her medical benefits. There may be limitations and exclusions to coverage. The patient portion is set by the insurance company. Patients are responsible for any co-insurance, deductibles, and any other non-covered billable services.

Payments: We accept Cash, check, Visa, MasterCard, and Discover. We also accept payment by check and debit cards. Delmarva Kidney & Hypertension Specialists will send patients accounts to collections for balances not paid after receipt of three statements unless you make payment arrangements with our billing office. We reserve the right to require payment for services to be made at or before the time of service.

Outstanding balances: We may refuse to see patients with balances over $250, and who are not making regular payments on the balance. In the event that your account is placed for collection, a collection fee will be added to your account, along with any attorney fees and/ or court costs that may be necessary for recovery of the outstanding balance. In the event of an NSF check, there will be a $30 NSF charge added to the balance due.

Cancellations/Missed Appointments: We charge $20 to your account if you do not call and cancel your appointment 24 hours ahead of time for all regular scheduled appointments. Notification allows the doctor to see another patient who needs to be cared for that day.

Claim Filing: We happily file your claim with your insurance company as a courtesy. Please keep in mind that payment remains your responsibility. We do not enter disputes over insurance benefits. We bill insurance in accordance with all federal, state and other contractual requirements in cases where we have an agreement or we are a participating provider. We expect payment in full from you if your insurance company delays processing of your claim for over 60 days. You agree to pay any portion of the charges not covered by insurance. If your insurance company sends payments directly to you, send or drop-off the payment to North Platte OB/GYN and we will apply it to your account.

Preauthorization: Most insurance companies require preauthorization before you have a surgical procedure. We will assist you with obtaining preauthorization for procedures. Failure to obtain preauthorization may result in your insurance company refusing to pay your claim. Any refusal of payment by insurance for this reason is your responsibility.

Referrals: If you see a doctor that is out of network or if you use an insurance company that requires a referral, you are responsible for obtaining it from your primary care clinic or physician. Failure to obtain it may result in a lower payment or no payment from the insurance company or no benefits from your insurance company and you will be responsible for payment.

Forms/Letters/Medical Records: The physician's office requires a minimum of 10 working days to complete FMLA, disability forms and letters required for the employer in reference to medical care. There is a $20 charge for each completed form or letters that a provider completes on your behalf. We charge a search fee of $20 and a copy fee of $0.50 per page for medical records requested for personal use.

Attestation Statement:
I have read, understand, and agree to the above Delmarva Kidney & Hypertension Specialists Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Delmarva Kidney & Hypertension Specialists.

I authorize Delmarva Kidney & Hypertension Specialists to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____
Print Name of Patient

_____ _____
Signature of Patient (or responsible party if minor) Date