Pine Hollow Partners, LLC
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Patient Financial Responsibility Policy

Pine Hollow Partners appreciates the confidence you have shown in choosing us to provide for your Autoimmune and/or Arthritic needs, and we are committed to providing you with the best possible care. The medical services you seek imply a financial responsibility on your part. Our ability to continue providing care to yourself and our other patients relies on these balances being paid. Your clear understanding of our financial policy is important to our professional relationship. Please feel free to ask any questions you may have.

Our receptionists will ask to see your insurance card at every visit and will scan your card into our system as needed to keep our information current and to facilitate accurate insurance billing.

Co-payments: Your insurance plan determines your co-pay and we require **payment at the time of service.** Please be prepared to pay the copayment at each visit. If you are unable to pay your copayment at the time of your visit, your appointment may have to be rescheduled.

Cost Shares: You will be responsible for your cost share for **any administration of treatment.** We will work with our Infusion Services Liaison to give you an estimate of the cost of these services based on information provided to us. However, it is not possible for us to give you exact amounts due to the fact that this is dictated by your insurance company. Please reach out to them for specific cost share information. **Each infusion patient will need their balance to be paid in full prior to their next service or infusion administration.**

Cancellation/Missed Appointment: If you do not show for your appointment or cancel with less than 24 hours' notice, a fee of $50.00 will be charged to your account. This charge will neither be submitted nor paid by your insurance company. It is your responsibility.

Self-Pay: You will be considered **self-pay** if you have no insurance coverage. Payment is expected at the time of service. We do have a self pay fee schedule for several services in the clinic and our receptionist can provide you this information as needed. If you are unable to pay the balance in full, you must meet with the Business Office to determine payment options; however all balances must be paid within 30 days.

Non-Participating Insurance Plans: As a courtesy to our patients, Pine Hollow Partners will bill your non-participating insurance plan. However, **a $75.00 deposit** is required at the beginning of your appointment. Any outstanding balances are the responsibility of the patient and must be paid within 30 days. If services are paid on an out of network fee schedule we can apply an overpaid amount to a future visit or reimburse the overpaid amount and make note of this for future appointments.

Referrals: If your insurance plan requires a referral form from your Primary Care Physician, **it is the patient's responsibility** to obtain a referral prior to your appointment and to have it with you at the time of your appointment. We will try to obtain it if we know there is one needed as a courtesy but If you don't have the referral, **YOU MAY BE REQUIRED TO RESCHEDULE** or sign a waiver accepting financial responsibility for the service.

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Medicare: Pine Hollow Partners will submit your claim to Medicare and upon receipt, we will also bill your secondary insurance if one applies. The patient will be responsible for the deductible and the co-insurance, if you do not have a secondary insurance.

Disability/FMLA/Insurance Forms: We require a nurse visit for all paperwork including FMLA, disability, ADA paperwork etc. This is to assure that we have the appropriate documentation for this paperwork and that the decision made is agreed upon and discussed between the patient and the provider. We do bill for these visits in an effort to eliminate an only out of pocket fee.

Returned Check Fee: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $35.00 fee per check returned.

Financial Responsibility of Patient:

I understand I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY MY INSURANCE which are collectable in accordance with the contract. I understand it is my responsibility to pay any incurred balance within 30 days of receipt of your billing statement. Should collection proceedings become necessary to an overdue account, the patient or the patients' responsible party understands that Pine Hollow Partners has the right to disclose to an outside collection agency all relevant and personal account information necessary to collect payment for services rendered. The patient or responsible party understands that they are responsible for all costs incurred during the collection process.

I hereby authorize Pine Hollow Partners to release all medical information to insurance carriers and/or Centers for Medicare/Medicaid concerning my illness and treatment and I hereby assign payment to Pine Hollow Partners for services rendered to myself/my dependent.

By signing below, I agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party. My signature verifies that I have read the above financial policy, understand my responsibilities, and agree to these terms.

For your convenience we accept CASH, CHECK, MASTERCARD, VISA, DISCOVER, and AMERICAN EXPRESS.

Signature of Patient, Power of Attorney **Date**

Printed name **DOB**

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