SPMG Financial Policy

Thank You for choosing our practice. We are committed to providing you with quality and affordable healthcare. Below is information to answer frequently asked questions regarding patient and insurance responsibility for services rendered. Please read it, ask us any questions that you may have, and sign in the space provided. A copy will be provided to you upon request. Thanks so much for being our patient.

PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN REQUESTED AND APPROVED IN ADVANCE. YOU ARE EXPECTED TO PAY ACCORDING TO THE ARRANGEMENT.

Deductibles and Co-Payments: **All deductibles, co-payments & Co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company.**

Insurance: We participate with most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. You and your insurance benefit is a contract between you and your insurance company.

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

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Methods of Payment: We accept payment by cash, check, Visa, MasterCard, American Express and Discover. If you opt for a credit card as your preferred payment you authorize Silver Pine Medical Group to maintain this card on file for balances due in full when it becomes your responsibility or in compliance with a predetermined payment plan.

Patient Statements: If you have an unpaid balance you will receive a statement by mail within two weeks, payment in full is due upon receipt, and if not paid is considered past due. A total of two statements will be sent. All payments made go to the oldest outstanding balance. Balances over 90 days will be turned over to a collection agency for collections, and if no response to the collection agency it may be turned over to an attorney.

Collection Fees: Balances that have not had a payment made within 90 days will be turned over to collections. Guarantor will be responsible to pay all costs of collections including reasonable interest, and reasonable collection agency fees not to exceed 33 1/3%.

No Show / Cancellation Fee: As a patient of Silver Pine Medical Group (SPMG), we want you to know that we value your time and commitment to improving your health and well-being. Because of that, we make every effort to see you as close to your scheduled appointment time as possible. In return, we ask that you kindly show the same consideration to our staff and fellow patients.

- If you are unable to keep your scheduled appointment, please call and provide notice **at least** 24 hours before your appointment time.

- Failure to cancel **at least** 24 hours prior to your scheduled appointment time will result in a $25 charge (late fee).
- Failure to show up to your scheduled appointment (without notice) will also result in a $25 charge (no show fee).

- If your appointment is a *Complete Physical Exam (CPE)*:
  - Failure to cancel **at least** 24 hours prior to your scheduled appointment time will result in a $50 charge (late fee).
  - Failure to show up to your scheduled appointment (without notice) will also results in a $50 charge (no show fee).

Patient Name: _____

Patient Signature: _____ Date: _____