MPFC Financial Policy

Medical Park Family Care, Inc (MPFC) is committed to providing information and quality services for all of our patients. We encourage our patients to take an active role in their care, interacting with our physicians, nurses and ancillary staff.
As part of our commitment to you, MPFC feels it is important that you understand your financial responsibility.
MPFC's policies are listed below. If you have any questions, please ask one of our staff to direct you to the Business Office for assistance.

PAYMENT AT TIME OF SERVICE/ADDITIONAL CHARGES (charges that may be billed after you leave MPFC)
MPFC expects payment at time of service, regardless of insurance status. If you do not have your insurance card at time of service, you may either pay in full or reschedule your appointment. If you have insurance, you will be required to pay your copay, or percentage, and any unmet deductible amount the day of the visit. The only exceptions to this are patients who have Medicare and Medicaid combined, or who have dual insurances that are contracted with MPFC and have met all deductibles.

_____ ***Pt Initial*** **Please be advised that some charges may not appear on your fee ticket when checking out, and are subject to change upon review. These may include, but are not limited to: lab, radiology and other ancillary service charges. Because some services may require additional laboratory tests or follow up, we cannot ensure that all the charges are indicated.**

> **A common example of this may be an infection or wound which needs to be cultured. Additional fees may be incurred after your visit, as some lab tests can result in the need for further testing or cultures. Once MPFC is charged by the lab up to several weeks later, the chart is reviewed and only then are the additional charges applied to the patient account and billed to the patient or insurance carrier as appropriate.**

SELF PAY – NO INSURANCE
If you do not have insurance, you will be expected to pay for your visit, including the office charges, laboratory fees, imaging/radiology and ancillary fees at the time of service. If you are a new patient to MPFC, we will require a $300 deposit in the form of a check, cash or credit card to be held at the check-in area prior to seeing the doctor. If you are unable to make this deposit your appointment will be rescheduled. The deposit also applies if you are unable to present your insurance card at time of service.

If you request an appointment and have an unpaid balance on your account, you will be referred to the Business Office to discuss your options for payment. MPFC payment plans are based on financial need and require the doctor's approval.

MEDICAID
Any patient receiving Medicaid benefits is required to bring their ID card to each visit. If you do not have your ID card your appointment may be rescheduled, or payment may be due at time of service as we do not retro bill Medicaid for services provided without an ID card. Any services performed that are not covered by Medicaid are your responsibility and due on the day you are seen. Any copay amount is due at each visit. MPFC is not accepting new Medicaid patients.

MEDICARE
Patients receiving Medicare benefits are required to pay their copay at each visit. Any service not covered by Medicare is your responsibility. You will be required to pay for your portion at each visit. You will be asked to sign a waiver of liability to ensure you understand your Medicare payment responsibilities. MPFC is not accepting new Medicare patients.

PRIVATE INSURANCE
MPFC will bill most primary insurance carriers. Payment for copays or deductible is expected at time of service. If you cannot pay for your portion you will be referred to the Business Office for payment arrangements. You will be responsible for any amounts where we were not given corrected or updated information by you at the time of service. You will be asked to sign a waiver for non-covered services, which your insurance may deem unnecessary or experimental and these may be your responsibility. If you do not present your insurance card at the time of service you will need to pay in full or reschedule your appointment. MPFC will bill secondary insurance plans as a courtesy. MPFC is a contracted PPO provider for the following insurance carriers: Blue Cross Blue Shield, AETNA, Cigna, First Choice, Moda and Multiplan/Beechstreet. If you do not know your copay amount, MPFC will expect the standard 20% at time of service. MPFC will assume if deductible status is unknown that it has not been met and will expect full payment at time of service.
Examples of **insurance plans we do not bill** are: Student Insurances, HMO's, Tricare, some out of state insurance plans which cannot be verified, Fisherman's Fund, and Third Party Auto Insurance.

FAA/DOT
These visits and related charges are typically not covered by insurance. Furthermore, as MPFC has a reduced fee schedule for these services we will not bill insurance for them even though some insurance companies may pay for such services. Payment in full is expected on the day you are seen.

NON-COVERED SERVICES
Some treatments are not covered by insurance and are expected to be paid at time of service. Because individual policies vary, it is not possible for our staff to know exactly what your policy will cover. We encourage patients to contact their insurance carrier to preauthorize treatment and inquire about deductibles and copay amount prior to their visit.

REFUNDS
At times, refunds or credits are created. If you receive indication from your insurance company that a possible refund is due, please contact our Business Office. Due to auditing purposes and policies once a refund has been identified by our staff, it may take up to 6 weeks to process and issue your refund.

_____ NO SHOW POLICY
Pt Initial Any patient who fails to arrive for a scheduled appointment, without canceling the appointment at least 24 hours prior to the scheduled time, OR arrives more than 10 minutes late is considered a "no-show" and will be assessed a **$35.00 "No-Show" fee.** A patient who no-shows more than three times within a twelve-month period will be dismissed from the practice.

COLLECTIONS
Payment for services received at MPFC is the responsibility of the patient or guarantor, regardless of insurance status.
MPFC does not appeal denials for usual and customary, preventative or non-covered services. If a patient refuses to remit payment or make financial arrangements, the patient account will be reviewed for possible collection action and the patient considered for dismissal from MPFC. Should your account go to an outside collection agency it will be assigned to **Cornerstone Credit Services.** You will be responsible for the above mentioned MPFC bill in addition to any collection agency charges.

If you have any questions regarding your financial responsibility to MPFC, please do not hesitate to ask. It is our hope that by providing this information, our patients will be more aware and empowered when receiving treatment at Medical Park Family Care. Our Business Office Number is 279-8486.

I have read and acknowledged the above financial policies

Signature_____ Date_____

INSURANCE ASSIGNMENT, AUTHORIZATION AND NON-COVERED BENEFITS WAIVER
I hereby assign benefits to be paid directly to Medical Park Family Care, Inc and authorize the clinic to furnish information regarding my illness to my insurance carrier. I understand that I am responsible for any amount not paid by insurance.
I understand certain tests or procedures are not a covered benefit within my insurance plan or policy. These tests may include but are not limited to Homocystine and Lipoprotein blood tests. I know that if I have any questions regarding what is or is not covered under my insurance plan or policy; I should contact my insurance carrier prior to having the test/procedure performed. If I have a test or procedure performed that is not a covered benefit within my insurance plan or policy, **I understand I am responsible for payment in full** for the incurred charges. I understand that MPFC will consider this waiver current for today's visit and any future visits, until I provide MPFC with different payer and /or insurance information.

Signature_____ Date_____

Patient Name_____ DOB_____
(printed)

3/4/2020 revised