



Red Alinsod M.D.
Maggie Carpio PA-C

PAYMENT POLICY v2.1

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured, or not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your **coverage.**
2. **Co-payments and deductibles.** All co-payments must be paid before or at the time of service. All deductibles must be paid when the amount is known. This arrangement is part of your contract with your insurance company. This fee is your responsibility. We cannot guarantee the deductible amount since it varies among patients and their plans and what services have been accessed in the recent past. It is best to call your insurance company.
3. **Non-covered services.** Please be aware that some-and perhaps all-of the services you receive may be non-covered, considered investigational by some health plans, or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **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 to provide proof of insurance. 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.
5. **Claims submission.** As a courtesy to you, 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. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. It is your responsibility to ask your plan what is covered and what is not covered.
6. **Coverage.** 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. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During the 30 day period, our physician will only be able to treat you on an emergency basis.
8. **Missed appointments.** We may charge a \$25 fee for missed appointments not canceled within 24 hrs. These charges will be your responsibility.
9. **Bounced checks.** Please be advised there is a \$25 fee for any bounced or returned checks.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party _____ Date _____

Print Name _____