

## OFFICE POLICIES

**Thank you for choosing Advanced Physical Medicine, Dr. Stephen Wilson, as your Pain Management, Rehab Medicine, and Medical Acupuncturist. 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 have, 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 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 and deductibles must 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-payments and deductibles can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

**3. Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered 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.** 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 this request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

**6. Covered 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. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.\**

**7. Non-payment.** If your account is over 60 days past due, you will receive a letter stating that you have 10 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 that 30-day period, our physician will only be able to treat you on an emergency basis.

**8.** By keeping your appointment we will be more effective in partnering with you to bring you better health. Please be courteous and call the office 24 hours prior to your appointment if you will be unable to attend, so that we may offer this time to someone who may benefit from being seen urgently. There is a \$25 fee for appointments not cancelled 24 hours prior to your scheduled time. These charges are your responsibility and billed directly to you.

*Our office 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.*

**BY SIGNING THIS FORM, I AGREE AND UNDERSTAND THE PAYMENT POLICY AND ABIDE BY ITS GUIDELINES. I HAVE RECEIVED A COPY OF THE OFFICE POLICIES BROCHURE IN THE NEW PATIENT PACKET.**

\_\_\_\_\_  
Signature Patient/Responsible Party

\_\_\_\_\_  
Date