CHARLES A. SAFELY, M.D.

Financial Policy and Business Office Procedures

Welcome to our practice. We are pleased to have the opportunity to serve your healthcare needs. The primary goal of our office is to provide you with quality, caring, and effective health care. The following outlines some of the financial and procedural steps required by your insurance or managed care plan, as well as the business procedures of our office. We believe your understanding of your insurance and our business office practices will help you make the most informed healthcare decisions and facilitate the therapeutic foundations of our work together. **Please read these policies carefully.**

_____Initial Office Visits:

At the time of your visit, we will need a copy of your current insurance card and a picture ID. Your insurance card must be presented at your initial visit. It is your responsibility to notify our office of any address or insurance changes or updates. Our office will not file retroactively on any claims. Co-pays, deductible, or co-insurance are due at the time of service or you may be rescheduled. I understand that my insurance policy is a contract between myself and the insurance company and Dr. Safely is not a party to that contract. We will bill your primary insurance 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 and financial liability. You are ultimately responsible for all unpaid balances and charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral or preauthorization may result in a reduction in payment or make you responsible for all charges.

_____Initial Appointments:

We make every effort to schedule an appointment that is convenient for you. Insurance information must be provided prior to your appointment or you may be rescheduled or pay as self- pay. It is important that changes be made well in advance of your scheduled appointment time. **Our office requires a 24-hour cancellation notice. A missed appointment or an appointment not cancelled within 24 hours WILL result in a $25.00 charge to you, which is not billable to your insurance company. This fee must be paid before a new appointment is scheduled.** If you need to reschedule or cancel an appointment, please call the office during normal business hours at (817) 284-1496. As a courtesy only, you will get an email and text message reminder for your appointment. We do not take walk-ins.

_____Initial Office/Hospital Surgery:

Insurance information must be provided prior to all non-emergency procedures, for obtaining pre-certification and benefits. An estimate will be given for deductibles, co-insurance, and/or co-pays, payable at the time of service for in-office procedures and prior to pre-operative visit for hospital procedures. For office/hospital-based surgery, please choose two dates (a primary and secondary date of preference). **Once the surgery is scheduled, should you choose to cancel or reschedule your surgery, a fee of $150.00 will be added to your account which cannot be billed to your insurance company and is payable prior to rescheduling your surgery.**

_____Initial Obstetric Care:

Co-pay, deductible or co-insurance will be due at the time of your first OB visit. Payment arrangements may be made and will be payable in equal increments to be paid in full prior to the sixth month of pregnancy. Although we estimate what your insurance company my pay, it is the insurance company that makes the final determination of your eligibility. Self-pay OB care requires a $1500.00 down payment on your first visit, unless prior arrangements have been made. **Problem visits, sonograms, and injections are not a part of Routine OB care. These are billed as a separate service. You will be responsible for co-pays, deductibles, co-insurance and services not covered by insurance.** If you have Medicaid you must bring your **hard copy letter** to each visit, temporaries will not be accepted.

_____Initial Post-operative/Post-partum Care/Well women exam:

Most post-operative/post-partum care is included in the global billing, however, if you have additional problems during your postop/post-partum care there will be an additional fee which will be billed to your insurance company. You will be responsible for any deductible/co-insurance and/or co-pays. Well women exams are billed separate from problem visits and are not done on the same day.

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_____Initial All Labs, X-rays, Certified Surgery Tech (CST), Radiologist, Pathologist, Anesthesiologist, and Hospitals are billed separate from our office. You may receive an additional bill **separate** from our office for these services.

_____Initial Forms/Medical Records/Letters:
Any forms or letters such as FMLA, Disability, Work release, etc that our office needs to complete there is a charge of $25.00 for each form and not billable to your insurance. Payment must be made before forms are completed. We require 72 hours or 3 business days to complete these forms. Medical records requested by the patient must be in writing. If records are to be released directly to the patient, there is a charge. The charge depends on the amount of copies plus postage and handling; this may also apply to records going to other physicians.

_____Initial CERTIFIED MAIL:
Should our office have to reach you by certified mail, a charge of $35.00 will be added to your account.

_____Initial Payments:
We accept Cash, Debit, Visa, Discover and Master Card at the time of service, unless prior arrangements have been made. Returned checks paid by mail on an existing account will be subject to a $35.00 return check fee. Unless other arrangements are approved by us the balance on your statement is due and payable when the statement is issued, it is past due if not paid by the end of the month.

_____Initial Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau and/or collection agency. If you're past due account is submitted to a collection agency, an attorney and/or reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

_____Initial Charges to account: A finance charge may be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of (1%) per month or an **annual percentage rate** of twelve (12%) percent. The finance charge on your account is computed by applying the periodic rate (1%) to "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days prior, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is $.50. Should your account go to a collection agency additional fees will apply.

_____Initial Authorization of payment, Release of Information and Treatment:
I hereby authorize payment to Charles A. Safely, M.D. of any medical or surgical benefits; this will remain in force until I revoke this authorization in writing. I also understand that I am ultimately responsible for medical expenses or services not covered by my insurance. I authorize Charles A. Safely, M.D. to release medical records, including HIV testing and/or drug abuse testing information, as requested by representatives of insurance companies or other related organization for payment of claims or as required by state or federal laws. I agree if account goes to collections, I will be responsible for all added/additional penalties and/or attorney's fees. I consent to office procedures and medical treatments unless these are specifically refused or declined in writing. I agree to all of the terms and conditions contained herein and the agreement will be in full force as of the date below.

Patients Printed Name: _____Date:_____

Responsible Party Printed Name (If not the patient):_____

Responsible Party Signature: _____Date:_____

Copy given to patient_____Date:_____