128 East Milltown Road, Suite 105
Wooster, Ohio 44691
330-345-8060

Financial Policy

Welcome and thank you for choosing Milltown Family Physicians, Inc. for your medical care. We are committed to providing you with the highest quality medical care possible in a cost effective manner. Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area. We are pleased to discuss with you any questions you may have concerning a bill.

Payment in full is due at the time services are rendered. As a courtesy to our patients, we accept cash, personal check, money order, Visa and MasterCard.

We also provide our patients the ability to pay for their accounts over the phone: **(330) 345-8060.**

In order to achieve our goal of providing you with the best care possible, we need your assistance and your understanding of our financial policy:

Our Office Hours are:

- Monday - Friday: 8am-12pm, 1:30pm-5pm
- Saturday: Open **SOME** Saturdays from 8:30 a.m. until the last scheduled patient.

Things to bring with you to EACH appointment:

- Health Insurance Card(s)
- Drivers License or photo identification
- Method of Payment

Appointments:

- Please arrive for your appointment 10 minutes early.
- If more than 10 minutes late for your appointment, you will be marked as a *No Show* and will need to reschedule your appointment.
- It is your responsibility to verify with your insurance carrier that your Physician is currently under contract with your insurance plan and that you have obtained all necessary referrals BEFORE your scheduled appointment. (Failure to confirm this may result in your responsibility for any and all charges.)
- Please inform the receptionist of any changes (phone number, address, marital status, insurance information, etc.). Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any services not covered by your insurance carrier.

Missed or Cancelled Appointments and other fees:

- If you are more than 10 minutes late for an appointment, you will be marked as a *No Show*.
- 3 *No Show* appointments in a 365-day calendar year will result in a dismissal from the practice.
- 2 hours notice is required to cancel and/or reschedule all appointments.
- All co-pays are due at the time of service. This is a contractual requirement from your insurance company. Any co-pay not received at the time of service will result in a $30 processing fee. If co-pay is received within 24 hours of the date of service, the $30 processing fee can be waived.
- There will be a fee of $30 for any returned checks to our office.
- All balances are due prior to any further service provided by our office.

In Network" vs. "Out Of Network" Insurance

- Your insurance coverage and benefits are a contract between you and your insurance company and therefore all disputes must be handled between you and your insurance company.
- We are contracted with multiple insurers to accept assignment of benefits.

Payment in full is due at the time services are rendered:

- Co-pays and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are due during the check-in process. Failure to produce payment at check-in may result in your appointment being rescheduled or the appropriate processing fee will be applied.
- If you receive more than one type of service on the same day, you may be responsible for more than one co-pay.
- Any amount not covered by the insured/patient's insurance is due within 30 days of the time of service.
- As a courtesy to our patients, we gladly accept cash, check, money order, Visa, or MasterCard.
- Failure to pay balances may result in collection activity and/or dismissal from the practice.

***Self-Pay* Patients**

- We offer a reasonable discount for our cash paying patients when paid in full at the time services are rendered. We will give you an estimate of what will be due prior to the appointment. Payment for services is due at the time of service.

Additional Paperwork:

- As a courtesy, our office provides completion of paperwork at no charge; however, a 72-hour notice is required for all paperwork.

Minor Patients:

- Parent(s) or guardian(s) must have an Authorization for Medical Treatment form signed and kept on file for a 6-month period when the minor arrives unaccompanied for an appointment. If there is a guardianship arrangement, we must have legal documentation of said arrangement.
- The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor as well as the payment in full for services provided.
- The guarantor/ insurance policy holder/ legal guardian is responsible for payment for services rendered to the minor patient.
- In compliance with HIPAA regulations, we are unable to discuss any details of services rendered or to produce an itemized bill for any parties that are not the legal guardian of the patient, unless otherwise documented.

Motor Vehicle Accidents:

- Motor Vehicle Accidents (MVAs) will not be billed to your auto insurance through our office. We will provide a claim form for you to forward to the responsible auto insurance carrier for reimbursement. The balance is considered a self-pay responsibility and should be paid no later than 90 days following the date of service.

Workers' Compensation:

- Our office accepts workers' compensation claims through Corporate Care through Wooster Community Hospital. If seen for a work related injury without making our staff aware that the visit is work related you would be responsible for the balance.
- In the event that workers' compensation denies your claim, it is your responsibility for payment for services rendered.

Lab/Hospital Charges:

- Any service(s) provided by Wooster Community Hospital and affiliated labs is a contract between you and that lab or hospital. Any dispute with that lab or hospital should be handled with that lab or hospital and is not the responsibility of our practice.
- It is your responsibility to know which procedures your insurance will and will not cover at these facilities and to request an Explanation of Benefits (EOB) from your insurance carrier.

Payment Plans:

- Our office will be happy to work with you in order to pay any balance due to our practice.
- Payment plan contracts are available online at www.MilltownFamily.com under the **Medical Forms** tab. Contracts can be mailed to our office or dropped off during business hours.
- Please contact our billing department to work out a payment plan with our practice at **(330) 345-8060 Ext. 5.**
- Please allow 5 mail days prior to each due date for each payment to be received by our practice.
- Please mail all payments to our office:
  128 East Milltown Road
  Suite 105
  Wooster, Ohio 44691
- Or over the phone: **(330) 345-8060**

Collections and Outstanding Balances:

- Any outstanding balance after 90 days of the date of service may be referred to an outside collection agency. Patients with unpaid delinquent accounts or accounts that are sent to collections may be dismissed from our practice.
- Accounts that have been turned over to Debt Recovery Solutions of Ohio Inc. (DRS) are now the responsibility of the collection agency. It will be your responsibility to contact **Debt Recovery Solutions of Ohio Inc.** at **1-866-589-3328** and make payment arrangements prior to scheduling any appointments. Failure to establish payment arrangements with Debt Recovery Solutions of Ohio Inc. will result in dismissal from the practice.
- Accounts that are placed with Debt Recovery Solutions of Ohio Inc. will be handled in the following:
  - If insurance coverage is present you are required to pay the copay amount at check in and the balance in full within 30 days of receiving a statement. As this amount is not considered part of your collection balance. Failure to do so could result in dismissal from the practice.
  - If you do not have current insurance coverage at the time of your visit you will be considered self pay and will be required to pay for the visit in full before leaving the office. Failure to make the

required self-pay amount could result in dismissal from the practice. However, the physician will see you for the scheduled visit as a last non-emergent visit.

- An account that accumulates more debt that is over 90 days old will be turned over to collections for a second time. In the event of a second collections account the patient/ family could be immediately dismissed from the practice.
- In the event an account if placed with Debt Recovery Solutions of Ohio Inc. and a payment plan has been established, failure to make the agreed upon payment amount and date of payment could result in dismissal from the practice.

Refunds:

- Refunds are issued to the appropriate party.
- Patient refunds will not be processed until all active or past due charges are paid in full.
- Refunds will not be issued, unless requested, and will be credited to your account at our practice. Patients will be notified of this.

By signing this document, I _____, have fully read and understand the financial policy of Milltown Family Physicians Inc.

I understand and consent to Milltown Family Physicians, Inc. I will cooperate with the billing department of Milltown Family Physicians, Inc. to ensure payment for my services. I understand that I will be responsible for any cost(s) associated with the collection of my account if I default on this agreement. I understand that the terms of this financial policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for payment for all services rendered to the patient herein.

_____
Printed name of patient/ parent/ guardian

_____ _____/_____/_____
Signature of patient/ parent/ guardian Month/ Day / Year

Please return signed document to the front desk. A copy is available for you if requested.

Milltown
FAMILY PHYSICIANS

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PERMISSION FOR TREAMENT

I/We _____ the _____
(relationship to minor)

authorize and/or delegate _____
(name/address/relationship)

_____

to act on behalf of me/us in the event I/we cannot be present, with power to obtain medical treatment, either by a physician and/or hospital for my named minor child(ren).

NAME	**DATE OF BIRTH**
_____	_____
_____	_____
_____	_____
_____	_____

This consent shall remain in effect from _____ **to** _____ **(not to exceed 6-months).**
(date) (date)

_____ _____
Signature Date

_____ _____
Printed Name Date

_____ _____
Witness Date

Rev: 2/14

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Co-pay Promissory Agreement

Dear Patient,

Your insurance company requires a co-pay to be paid when you seek certain medical services. In turn, **we have a contractual obligation** to collect co-pay from patients when it is due.

If a patient desires to be seen and is unable to pay their co-pay, we are requiring those patients to sign a 'Co-pay Promissory Agreement' and pay the required co-pay to our office by ***end of business day on the date of service***.

I, _____, understand that my insurance company requires co-pay be paid for healthcare service provided to me, or my dependent. On this date, I desire to receive services without paying the required co-pay at the time of service.

I promise and attest that I will pay the required co-pay of $ _____ (as noted on my insurance card) to Milltown Family Physicians by ***end of business day on the date of service***.

Failure to make payment by ***end of business day on the date of service*** will result in an additional **$30.00 administrative fee to be added to the original co-pay due.**

I also understand that failure to make the required payment may result in collection proceedings, notification to your health insurance administrator, credit degradation, and dismissal from our practice.

You may return to our office on the date of service and pay by cash, personal check, or credit card. If you wish to telephone your payment by using a credit card, please do so by calling the number above and request the billing department.

Signature_____ Date_____

Printed Name _____

Patient's name if different than signer _____

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Billing – Your Charges

Your fee is based upon multiple considerations. The first is your recognition of the value of our medical opinion. Other factors include time spent with you during your visit, the complexity of your medical condition and any treatment that is provided. But proper attention to your care also requires additional time spent beyond that of when you are in the office. Such time may be used or include:

- Create or maintain your permanent medical record.
- Review, interpret and document all lab test results and communicate those results, orally and/or in writing to you.
- Review current X-ray or scan reports, compare them with reports of previous scans, and, when the studies are abnormal, consult with the radiologist.
- Prepare and mail consultation reports and letters suggesting patients come in for a follow-up visit.
- Consult via phone about your case with referring or consulting physicians and other health care providers.
- Prepare referral letters to additional specialists, as needed.
- Prepare patient education materials.
- Conduct medical research relevant to your case.
- Communicate with pharmacies about your prescriptions.
- Complete insurance applications and claim forms.
- Conduct utilization review negotiations with hospitals and insurance companies.
- Review and manage hospital records.
- Draft letters of necessity to obtain medical services, instruments or prescriptions that you need.
- Draft reports and forms, including home health care orders and nursing facility orders.

All these activities add to our cost of providing you with quality healthcare services. Still, we are committed to providing you our services at the lowest cost possible.

We hope this explanation of our fees has been helpful. With you, our patient, we look forward to a lasting and health relationship.

Sincerely,
Milltown Family Physicians

Milltown
FAMILY PHYSICIANS

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To our families:

Insurance coverage if often very different from plan to plan. We do not know the specific coverage of your plan. It is *your* responsibility to know the services and the providers covered by your insurance plan. Many of our families have been billed for services that they thought would be covered by their insurance. Some of the services that may not be covered or have limited coverage are:

Lab Work

Some insurance plans do not cover lab work performed at the Wooster Hospital Lab in the Milltown Professional Building. BEFORE the lab work is performed you need to tell us if your insurance company requires lab work to be sent to a different provider.

Immunizations and Medications

Immunizations and medications can be very expensive. Nearly all insurance plans have annual limits on the amount they will pay for immunizations and medications. Some plans provide no coverage at all. If your plan has little or no coverage, you may consider contacting the local health department regarding their immunization program.

Developmental Testing, Hearing and Vision Testing

These tests may not be covered by some insurance providers, so please check on your policy's coverage.

Combining Well and Sick Visit

Combining a well and sick visit at one time benefits the patient and family, but insurance companies still view it as two visits. It is your insurance company that requires a second co-pay to be collected.

You may be responsible for any services not covered by your insurance company.

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Well Visit and Other Concerns

If you or your child has an appointment for their yearly well check or physical and you have another concern or problem, it may require an additional evaluation and/or treatment by the doctor. An additional charge may be billed to your insurance. Depending on your individual insurance plan, a second co-pay may be required or a portion of the charges may not be covered.

Included in a routine well visit is:

- An age and gender appropriate health history
- Assessment of age-pertinent risk factors
- A comprehensive exam

An additional sick visit would also include:

- History of the current concern/illness
- Appropriate exam based on the illness
- Prescribing medications, ordering labs, x-rays or other testing, referrals to a specialist

We will attempt to address/treat your additional concerns with the well visit, but another visit may be required for more complex issues.

We will submit the charges to your insurance and send to you a bill if additional payment is required.

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Patient Payment Plan Contract

We have noticed a significant increase in the number of patients not fulfilling their obligation to pay their deductible, co-insurance, co-payment and non covered services. We have implemented a payment plan policy to help solve this growing problem.

I understand that I am enrolling in a payment plan to fulfill the balance of my account. I will make payments to Milltown Family Physicians, Inc. as described below.

Payment will be made by (cash/ check/ credit card)
Please circle one

Payment amount promised $ _____ (weekly, bi- weekly, or monthly)
Please circle one

Date of First Payment: _____

Patient(s) Name: _____ **Date:** _____

Patient(s) Signature: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: ( ) _____-_____

I authorize Milltown Family Physicians, Inc. to charge my credit card for the balance of charges not paid by my insurance plan including deductibles and co-insurances for all patient accounts listed.

I understand this amount will be charged as specified above until the account has reached a zero balance.

I understand this form is valid for one (1) year unless I cancel the authorization through written notice to Milltown Family Physicians, Inc.

Name on Credit Card: _____

Credit Card Number: _____ **Expiration Date:** _____

_____ _____
Cardholder Signature **Date**

Rev. 2/2014

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Self Pay Payment Plan

I understand that I am enrolling in a payment plan to fulfill the balance for services rendered on _____. In the event that there is a balance on the account, it will be added to today's charges. I will make 3 payments to Milltown Family Physicians, Inc.

This plan will expire 90 days after the date of service. Balance must be fulfilled by this date. If balance remains at the expiration date account will be forwarded to collections and to your physician for potential dismissal.

3 payments (specified below) to fulfill the balance of $_____.

Payment will be made by (cash/ check/ credit card)
Please circle one

Payment 1- $_____ Date: _____

Payment 2- $_____ Date: _____

Payment 3- $_____ Date: _____

_____ _____
Patient and/or Cardholder Signature **Date**

PATIENT NAME: _____

PATIENT ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PATIENT TELEPHONE NUMBER (_____) _____-_____

CARDHOLDER NAME: _____

CREDIT CARD NUMBER: _____

EXP. DATE: _____ **CARD TYPE:** VISA ___ MasterCard ___

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NOTICE OF NON-COVERED SERVICES

Medicaid's Family Planning program *only* covers the following services:

- **Pregnancy prevention**
- **Diagnosis and treatment of STI's, other than HIV or Hepatitis B**
- **Mammography when indicated by a breast examination**
- **Vaccinations against Human Papillomavirus (HPV) or Hepatitis B**

If you choose to have services that are considered non-covered under your current Medicaid plan you will be 100% responsible for the charges.

Patient Name: _____ **Date of Service:** _____

Medicaid's Family Planning program will not provide reimbursement for the following services.

Description of service(s):

- _____ **Cost:** _____
- _____ **Cost:** _____
- _____ **Cost:** _____
- _____ **Cost:** _____
- _____ **Cost:** _____
- _____ **Cost:** _____

Total: _____

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Signature: _____ **Date:** _____