



## SCOS Policy

Thank you for choosing us as your healthcare 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 have, and sign in the space provided. A copy will be provided to you upon request.

**Missed Appointments** - Our policy is to charge for missed appointments not canceled within 24 hours of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our charges are as follows:

Office Visit	\$50.00
MRI	\$75.00
Physical/Hand Therapy	\$50.00
Surgery	\$250.00

**Form Completion** – There may be a charge of \$25.00 to \$50.00 for each form a patient may request us to complete such as: DMV forms, Assisted Living forms, health assessments, letter(s) to third parties, etc. If forms or reports are lengthy, charges may be higher depending on the amount of time spent on completion. **This charge is not covered by your insurance.** Please allow 72 hours for completion of all forms.

**Patient Portal** – The patient portal is SCOS's preferred way of communication to our patients. We utilize the portal for exchanging secure messages, medication renewals, appointments referrals and test results.

**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 from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

**Return Check Charge** – All accounts with checks returned from the bank for any reason will be assessed \$25.00 per returned check.

**Insurance** - We participate in most insurance plans, including Medicare and Monarch, Greater Newport and Memorial Care. 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. Verification of insurance or authorization is not a guarantee of payment. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**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.

**Proof of insurance** - All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card 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.

**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 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. After the initial billing, the patient must assume responsibility in collecting from the insurance company.

**Coverage 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 in 45 days, the balance will automatically be billed to you.

**Nonpayment** - Patient responsibility is due 15 days upon receipt of billing statement. In the event of late or nonpayment of any portion of patient responsibility 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 will be responsible for all outstanding balances, including any collection agency fees accrued. As a result, you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular and/or 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.

**Prescriptions** - All prescription refills should be requested prior to 4:30pm, Monday – Friday. We do not approve refills prescription during off hours.

**Medical Records** - Copies of your medical records are available upon request for a \$25.00 fee. Please allow 5 working days from receipt of your payment for the records.

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 policy. Please let us know if you have any questions or concerns.

**I have read and understand the policy and agree to abide by its guidelines:**

**Patient Name: (Please Print):** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_