SAN JUAN HEALTHCARE
BILLING AND FINANCIAL POLICY

1. **Insurance co-payments must be paid on the day of service.**

2. **If you do not have health insurance, we request that you make a payment of $50. on the day of service**. Additionally, we offer a **15% discount on provider services** when full payment is made on the same day of service, including payment by charge card. Lab, vaccines and other supplies are not discounted.

3. **We accept VISA and MASTERCARD** for your convenience.

4. **Please present your insurance card for verification at every visit**. During these changing times, employers and individuals frequently switch insurers.

5. Remember, if you have insurance, the contract is between you and your insurance company. **You are responsible for any balances after insurance is processed**. If information you provide us about your coverage is current and complete, this helps us keep overhead and prices down. If rebilling is necessary, this ultimately increases the cost of your health care.

6. **We use a billing service, Automated Health Services of Bellingham (AHS).** If you have questions about your account, please contact them at 1-888-729-7202 We will be happy to accept any payments on account here in the office if you bring your statement with you. We can also process your VISA and MASTERCARD payments on your bill here in the office as the billing company is unable to process charge card payments.

6. **Know your insurance benefits**, what is covered, how often and what is not allowed. We will make every effort to code and bill your insurer properly. We are unable to change billing codes and diagnoses after they are submitted; to do so is considered fraudulent. <u>We have no way of knowing if your last well exam was 23 months ago and your insurer pays for one every 24 months. You are responsible for any services provided that are rejected as a noncovered service by your insurer.</u>

7. There is a $25 charge for any check returned due to insufficient funds.

8. Past due accounts will be referred for collection at our discretion.

Release of benefits and information: I authorize my insurance benefits to be paid directly to my health care provider. I am financially responsible for non-covered services. I also give permission for release of information required to process the claim. I accept the billing policies as explained above and agree that I am responsible for any balances due.

Name of Patient: _____

Name of Guarantor:_____Relationship: _____

Signature:_____Date_____