

William A. Ingram, MD, PC Financial Policy

Insurance: The Practice will file claims with both your primary and secondary insurance companies. It is the responsibility of you, the patient, to familiarize yourself with the coverage, benefits and eligibility provided to you through your individual insurance plan. Your insurance carrier makes the final determination regarding eligibility and coverage. You agree to pay any portion not covered by your insurance. Insurance changes must be brought to our attention immediately as you, the patient, will be responsible for all charges not paid as a result of any change in insurance coverage. If the insurance company does not pay within 45 days following the submission of your claim, you are responsible for the remaining balance.

Co-Payments: If your coverage requires a patient co-pay, we are obligated by your insurance carrier to collect your co-pay at the time of service. Failure to collect co-pays puts both the patient and William A. Ingram MD, PC in default of the insurance contract. Please be prepared to pay the co-pay at each visit. Without it, you may be asked to reschedule.

Deductibles: If your coverage includes a patient deductible, you will be asked for **payment in full** at the time of service. Patients with high unmet deductible plans will be asked to remit a minimum deposit of \$150 at the time of your visit. Any remaining balance will be due at the time you receive your statement.

Self-Pay Patients: If you do not have insurance, you will be asked to pay for services at the time of your visit. For many services, you will receive a 20% discount for payment in full on the day of your visit.

Medicare: William A. Ingram, MD, PC accepts Medicare assignment. By accepting assignment, Dr. Ingram agrees to accept Medicare's approved amount as payment for the services covered. You, the patient, are responsible for any remaining balances. We will file a claim with your secondary insurance plan for you.

Medicare ABN Form: If you receive a service that may not be considered medically necessary by Medicare, you will be advised by the clinic staff and asked to sign an Advanced Beneficiary Notice (ABN). Medicare's determination that a service is not medically necessary does not mean that the service should not be provided to you. Dr. Ingram will recommend services based on your current health condition and his expert medical opinion. The ABN Form is your advance notification that the service(s) may not be covered, and you may be financially responsible. Testing or treatment will not proceed without your informed consent.

Medicaid: It is the patient's responsibility to ensure that their Medicaid coverage is current and that our Practice is specifically accepted by their individual plan. Please bring your current Medicaid card with you to each visit or "proof of coverage." If a co-pay is required, your co-pay is due at the time of service.

Referrals: If you have an insurance plan that requires a referral from your primary care physician prior to a visit to a specialist, it is YOUR responsibility to obtain the referral. If you choose to seek the services of William A. Ingram, MD without the referral, YOU will be responsible for the payment of the charges, should your insurance company not approve the charges.

Patient Statements: You will be mailed your patient statement if a balance is due on your account. Payment is due upon receipt of your statement. Please contact our Billing Department at 1(888) 611-0851 for questions or concerns regarding your statement.

Payment Arrangements: If you are unable to pay for your patient statement balance in full, contact our Billing Department at 1(888) 611-0851 to discuss payment options. Payment plans may be available to settle your balance within 90 days.

Outstanding Balances: If you have any outstanding self-pay or insurance designated outstanding balances for co-pays, deductibles and other unpaid out-of-pocket expenses, you will be asked to remit payment at your next visit.

or you may be required to reschedule your appointment. Chronic non-payment of bills can constitute separation from the practice.

Collections: Unpaid balances will be forwarded to our collection agency. Once an account has been referred to a collection agency, you must work directly with them to satisfy your debt. If you return to our office for services, you will be required to pay in full **prior** to receiving any future services.

Payment Methods: We accept cash, checks and most major credit cards. There will be a fee for returned checks.

All fees for the professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

If it is necessary to turn the fee(s) for services rendered over to collection for non-payment after 60 days, then the patient is responsible for the bill, interest, collection and attorney fees.

No-Shows and Late Arrival Fee(s): Our office charges for No Show/Missed Appointments, including late appointment check in. We understand that emergencies happen and we allow one (1) waiver (free pass) per patient. Please observe the following:

- If you can't make your scheduled appointment, you must contact our office 24 business hours in advance to cancel/reschedule your visit.
- If you fail to cancel/show up for your appointment, you will be reminded of our no-show policy and asked to make a non-refundable deposit toward your next visit.
 - Note: This fee is the responsibility of you, the patient, and we will not bill your insurance for this fee.
- If you fail to cancel/show-up a second (2nd) time, you must pay for your appointment in advance to reschedule.
- If you are chronically late or fail to cancel/show-up a third time, you will forfeit your payment and be dismissed from the Practice.

I have read the Financial Policies of William A. Ingram MD, PC and agree to comply with the Financial Policies. In addition, William A. Ingram MD, PC has my permission to provide medical documentation in order to obtain reimbursement.

Printed Patient Name: _____

Patient Signature: _____ Date: _____

{Patient or Parent of Minor}