OFFICE POLICY

Having the following policies in place allows Primary Care Associates, PC to better serve our patients.
Please read and sign at the bottom.

1. **Insurance.** Your insurance policy is a contract between you and your insurance company. Knowing your insurance benefits, whether or not you are within your managed care network, and if certain procedures require pre-certification are your responsibilities. Because all plans are different, please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments, deductibles, and non-covered services.** All co-payments, deductibles, or percentages must be paid at the time of service. This arrangement is part of your contract with your insurance company. Payment of your portion of the charges is expected from the present party when services are rendered. 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.
3. **Proof of insurance.** We must obtain a copy of your driver license or government issued photo identification and current valid insurance before any patient can be seen. 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 you fail to provide us with the correct insurance information at the appropriate visit, you may be responsible for the balance of the claim.
4. **Claims submission.** We will submit most claims as a courtesy and assist you in any way we can reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If your claim is over 60 days from the date of service, it may not be filed or refiled for benefits.
5. **Nonpayment.** Payment in full is required on a timely basis, regardless of whether any third-party payment is pending. If your insurance company does not pay your claims in 45 days, the balance may be billed to you. Please be aware that if your account is over 90 days past due, we may refer your account to a collection agency. If so, you will be responsible for all additional charges equal to the cost of collection, including agency and attorney fees and court costs incurred and permitted by the Tennessee laws governing these transactions. You and your immediate family members may also be discharged from this practice. Partial payments will not be accepted unless otherwise negotiated.
6. **Missed appointments.** Because your scheduled appointment is time reserved for you, our policy is to charge for missed appointments not cancelled within a reasonable amount of time. After three missed appointments, you and your immediate family may be discharged.
7. **Administrative fees.** We will be glad to assist you in completing necessary medical paperwork. Please complete your portion and bring the paperwork with you to the appropriate visit. Otherwise, there will be a charge to have it completed. This includes but is not limited to, forms for disability, FMLA, insurance applications, medication assistance, and health certification for adoption.
8. **Medical records.** There is a charge for printing medical records. Please allow ten (10) days for us to complete.
9. **Insufficient funds.** If a check is drawn on insufficient funds, a service charge will be added to your account. For visits following, you will be asked to pay by cash or credit card.
10. **Prescription refills.** Prescription refills will only be approved during normal business hours and not during sick clinic or after hours. It is not our policy to call in medications without the child being seen first, unless it is a refill.

I hereby authorize Primary Care Associates, PC to disclose any information necessary for the processing of my claims related to my treatment at Primary Care Associates, PC. I understand that this authorization extends to the treatment and furnishing a copy of all reports related to my treatment. The question of privacy between Primary Care Associates, PC, my treating healthcare provider, and myself are waived with regards to the information contained in the records and reports furnished to my insurance carrier. I understand my insurance carrier may not cover and/or pay for services rendered, and I agree to be financially responsible for any services that are not covered by my insurance carrier.

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Signature of patient or responsible party Date