Matthews-Vu
Healthcare for Children and Adults

Patient Name: _____ Date of Birth: _____
Account Number: _____

Financial Payment Policy

Thank you for choosing Matthews-Vu Medical Group as your primary care provider. As part of our commitment to offer quality medical and affordable health care, we are also committed to building a successful provider-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is part of that relationship. If you have any questions about our fees, or your responsibilities, please ask. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.)

1. **Insurance** – Our office participates in many insurance plans. If you are not insured by a plan we have a contract with, payment in full is expected at each visit. If you are insured by a plan we are contracted 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. Knowing your insurance benefits is your responsibility. Your insurance benefits is a contract between you and your insurance company; we are not party to that contract. Failure to provide complete insurance information results in patient responsibility for the entire bill. Please contact your insurance company with any questions you may have regarding your coverage. As a courtesy, we will file all applicable office charges with your insurance company. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If the provider deems **medical necessity** for certain services/test and these services/tests are not covered or not considered reasonable or necessary by insurers, the patient is financially responsible.

2. **Co-payments and deductibles** – **All co-payments, deductibles and/or co-insurance must be paid at the time of service**. We accept Cash, Checks, Master Card, Visa, American Express or Discover. 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 uphold the law by paying your co-payments at each visit. Patients with **high deductible health insurance plans** will be required to pay a deposit of $70 for each visit (unless you have a letter from your insurance company stating you have reached your deductible). Patients are responsible for working with their insurance company to know if they have reached their deductible. If a patient pays $70 and the insurance company determines the patient has already met this year's deductible, the business office will issue a refund. If you are not able to pay at the time of service you must call the business office and set up a payment plan prior to your appointment.

3. **Self-pay Accounts** – Patients without insurance coverage, or patients without an insurance card on file with our practice. It is the patients' responsibility to know if Matthews-Vu Medical Group participates with their health insurance plan. Self-pay patients will be required to make a deposit of $70 prior to appointment. After the visit, the patient will be required to pay the estimated remaining balance. After the claim has been reviewed by the business office coding team, a final bill will be determined and reconciled against the payment paid at time of service. If a balance is due from patient, the business office will submit a statement to the self-pay patient. If a credit balance is owed to the patient, the business office will issue a refund.

4. **Missed Appointments** – Matthews-Vu Medical Group requires 24-hour notice of appointment cancellation. Appointments missed that are not previously canceled may be charged a fee of $50.00. Please help us to serve you better by keeping your regularly scheduled appointment. If we determine a patient is an habitual offender of missed appointments, then we will request a $50.00 deposit prior to scheduling the next appointment.

5. **Return Checks** – The charge for a returned check is $30 payable in cash or credit card. This will be applied to your account in addition to any bank-insufficient-funds charge incurred by the practice. You may be placed on a cash or credit card only basis following any returned check.

6. **Outstanding Balance Policy** – Patients will receive a monthly statement with any outstanding balance of $5.00 or more. Please be aware that the balance after insurance pays is the patient's responsibility. If your insurance company does not pay your claim in 60 days, the balance may be billed to you. Patients can make payments by paying with check or by going online and using the patient portal to process a credit card payment. Patients can also call the billing office at (719)884-2799 to process a credit card payment over the phone. We accept Checks, Master Card, Visa, American Express or Discover. If your account becomes past due over 60 days, you will receive a phone call. On a case by case basis, a payment plan can be established with a credit card on file.

7. **Nonpayment** - If there was no attempt on the patient's behalf to contact and set up a payment plan, and your account is over 90 days past due, you will receive a letter stating you have 20 days to pay your account in full. Please be aware that if the balance remains unpaid, we may refer your account to a collection agency (patient responsible for collection fees) and you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

This financial policy helps the office provide quality care to our valued patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

_____ _____

Patient/Guardian Signature Date