



Deerpath Primary Care Payment Guidelines

Thank you for choosing Deerpath Primary Care, SC (DPC) as your health care, medical home. We are committed to providing you with the highest quality, affordable health care at the right time and in the right place. We have developed a payment policy because some of our patients have questions regarding insurance. Your clear understanding of our Financial Policy is important to our professional relationship.

1. Payment.

- a) *Insurance & Copayments.* A copy of your current insurance card and driver’s license will be taken at the time of service. All copayments and deductibles are paid at the time of service. Depending on your insurance plan, a deductible may need to be met before an insurance company will cover services. Any services not covered but applied to your deductible are your financial responsibility to pay to DPC. If you do not pay your copayment at the time of service, we will bill you with an additional \$20.00 charge.
- b) *Self-Pay & Out of Network.* A pre-service deposit may be required at the time of service. You will be billed the remaining balance of rendered services. You will be responsible to submit a claim to your insurance company if you have an out-of-network insurance plan. Cash fees are usual and customary for our specialty in our locality.
- c) *Methods.* DPC accepts Visa, MasterCard, American Express, Discover, cash, and checks (\$25.00 service charge for all returned checks).

2. Real-Time Adjudication.

- a) *United insurance plans.* If you have United health insurance, we will conduct “real-time adjudication”, a process that allows DPC to determine the amount your insurance company will pay for directly after your visit. Your balance will be known immediately and DPC will collect this amount at the time of service via normal methods of payment.

3. Balances.

- a) *Pre-Authorized Payment.* DPC asks you give permission to charge your credit card automatically for any unpaid balances we identify only on your EOB (“Explanation of Benefits”) from your insurance company. After claims are processed, you may still owe an additional payment for your visit. At each visit, we will ask you to sign a pre-authorization form for payment on your current credit card and obtain a copy of a credit card. We will also ask for your current email address to notify you of the amount and date of transaction. A second email will confirm payment is made with a receipt for your records.
- b) *Collections.* Insurance companies may deny or reduce payments due to your coverage. Following DPC receipt of denial or reduced payment, your Pre-Authorized Payment credit card will be charged or you will be billed. If billed, you will be sent 3 statements over a 70 day period. If nonpayment occurs and we are unable to reach you for payment after 2 phone call attempts, your account will be sent to collections.

4. Missed Appointments.

- a) Our policy is to charge for missed appointments not canceled within appropriate time of your scheduled appointment. For New Patients, VIPs, and physicals, cancellation is necessary the day before the scheduled appointment. A charge of \$150.00 will be incurred on your credit card if not satisfied.
- b) For all other appointments, cancellation can be made within 4 hours of the scheduled appointment. Please help us serve you better by keeping your regularly scheduled appointment. This is also applicable to cancelling appointments via the Patient Portal.

5. Refunds.

- a) If you insurance company overpays for your rendered services, we will refund the insurance company. If you overpay DPC for any patient balance or patient financial responsibility, DPC will refund you the appropriate amount within 60 days of overpayment via a check mailed to you.

6. Security.

- a) All credit card information is secure and in compliance with current standards. We will contact you within 1 business day if changes occur to your information.

By signing below, I acknowledge I have received this Payment Policy. I understand that I am entitled to ask for the cost prior to receiving any services.

Patient Name (Please Print)

Patient/Responsible Party Signature

Date