INTERNAL AND WELLNESS MEDICINE
1630 Mineral Springs Ave, Ste 2, North Providence, RI 02904
Phone: 401-438-1010 Fax 401-354-4760

PRACTICE FINANCIAL POLICY

If you have medical insurance, we will try our best to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our financial policy.

CO-PAYMENTS AND DEDUCTIBLES: These payments must be made either at time of service or at check-in. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients is considered a violation of contract and fraud. Please help us uphold the law by making your co-payments at each visit and paying deductibles owed at the beginning of the year (including Medicare deductibles and 20% co-insurance).
An administrative fee of $5 will be added to your bill if you fail to pay your copay at the time of the service.

CLAIM SUBMISSION: As a courtesy to you, we will process and file your insurance claims for services rendered by our Practice. Your insurance company may need additional information from you to process a claim, and it is your responsibility to comply with their request. Your insurance is a contract between you or your employer and the insurance company. While we may provide services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.

NON-COVERED SERVICES: Not all services are covered by insurance; they vary from contract to contract. Some insurance companies arbitrarily select certain services they will not cover or which they may consider not medically necessary. In these instances, you will be responsible for these services. We will make every effort to ascertain your coverage for our services **before** treatment and make you aware of our findings. However, this does not guarantee payment from your insurance carrier.
For services that are not covered by insurance, the Practice requires payment of 100% of the total charges at time of service unless prior arrangements have been made.

COVERAGE CHANGES: If your insurance changes, please notify us as soon as possible so that we can update our records and help you receive the maximum benefits allowed under your coverage. If you are insured by a plan that we accept, but you do not have a current insurance card, payment is expected in full at time of service until we can verify your coverage.

MISSED APPOINTMENTS: We require 24 hour notice for an appointment cancellation. Please be aware that there is a $30.00 fee for missing a scheduled appointment. These charges are your responsibility and are not billed to your insurance company. Please help us in serving you better by keeping your scheduled appointments or by giving 24 hour notice before any cancellation.

NONPAYMENT: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full or make payment arrangements with us. Please be aware that if your balance remains unpaid, we reserve the right to refer your account to a collection agency, and your account will become inactive until paid. Account balances turned over to a collection agency will accrue interest at the rate of 16% per annum, or 1.33% per month after 90 days. If your account is turned over to an attorney or pursued legally for collection, you will be responsible for all reasonable attorney's fees, filing fees, and service fees.

All Returned Checks Are Subject to a $30.00 Fee.
We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Our Practice is committed to providing quality medical care. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our financial policies. Please let us know if you have any questions or concerns about the above information or any uncertainty regarding your insurance coverage. ***We are here to help!***

PLEASE READ THE ABOVE FINANCIAL POLICY CAREFULLY BEFORE SIGNING.
I hereby authorize photocopies of this form to be as valid as the original.

Signature: ____ Date: ___________________