Southern Regional AHEC
Patient Responsibility Policy

Patient Name: _____ Chart #:_____

To: All Southern Regional AHEC Patients

The following information is provided to avoid any misunderstanding or disagreement concerning payment for medical services that you receive from Southern Regional AHEC and our healthcare providers. We strive to ensure that we provide you with a clear statement of our financial policy and your financial obligations with respect to the medical services that we provide.

1. **Insurance Plans-Participating Providers**. Our office participates with a variety of insurance plans. The plans in which we participate may vary from time to time. If you have any questions regarding whether we currently participate in your insurance plan, please contact our office. If you are enrolled in a healthcare plan in which we participate, it is your responsibility to:

    i. **Bring your current insurance card to every visit**
    ii. **Be prepared to pay your co-pay and/or deductible at each visit**

2. **Insurance Plans-Non Participating Providers**. We are willing to provide you with medical services even if we do not participate in your insurance plan. If we are not a participating provider with your insurance company, **payment in full is expected at the time of service.** Our billing office is happy to assist you to file the claim for reimbursement for our services from your insurance company. Please keep in mind that in certain instances you may be subject to higher co-payments or deductible amounts in the event you seek care from a non-participating provider.

3. **Payment for Non-Covered Services**. Regardless of whether we participate with your insurance plan, certain services that we render may not be covered by your insurance. These may include services that your insurance plan considers to be cosmetic, experimental or not medically necessary. For medical care not covered under your insurance, **payment in full is expected at the time of the visit.** As insurances have different rules and requirements regarding medical care covered by its policies, please contact the insurance company member services department for your insurance company if you have any questions regarding whether the services you will receive are covered under your insurance plan. The phone number for the member services department is located on your insurance card.

4. **Referrals**. Under certain insurance plans you are required to receive a referral from another provider (often your primary care provider) in order for the services provided by Southern Regional AHEC to be covered under your insurance plan. This requirement may apply regardless of whether we are participating provider with your insurance company. It is your responsibility to obtain and to provide evidence to us of any required referrals for treatment at, or prior to, the visit. If you do not obtain the necessary referral, you will be financially responsible for all services provided by Southern Regional AHEC. In addition, Southern Regional AHEC reserves the right to reschedule your appointment (other than in the case of emergency treatment) if we recognize that you have not provided us the required referral documents.

5. **Payment Plans**. In certain instances, we may be able to work with you to establish a monthly payment plan. If you are unable to pay for necessary medical care, it is your responsibility to inform us as soon as possible, preferably, prior to the visit so that we can work with you to determine whether a payment plan or other option is available. If you receive a bill from us and cannot pay the entire balance when due, it is your obligation to contact our patient accounts department as soon as possible. All calls regarding payment plans and unpaid balances should be directed to our patient billing department at 910-678-0101. The minimum acceptable payment on a payment plan is **$25.00** until paid in full.

6. **Referral to Collection Agency.** Southern Regional AHEC reserves the right to turn any patient over to a third-party collections agency to collect any amounts not paid in conformity with this policy. We will not turn over to a collection agency, however, if you establish a monthly payment plan with us and fulfill your obligation under that plan, including paying all monthly installments when due. Failure to make prompt payment on your account could also result in discharge as a patient from our practice.

7. **Methods of Payment.** Payments may be made by cash, check, money orders, debit and credit card (**Visa or MasterCard Only**). A $25 returned check fee will be assessed to your account for every check returned for insufficient funds. Patient with two or more returned checks must make future payments by cash, credit card or money order. Self pay patients will receive a 20% discount when paying your account in full at the time of service.

8. **Minors**. If the patient is a minor (17 years and younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at the time of service, bringing the necessary referrals and insurance card.

9. **Rescheduled Appointment**. If you are not able to keep your scheduled appointment, we ask that you cancel or reschedule 24 hours prior to your appointment. Repeated failure to do so could result in discharge as a patient from our practice. Failure to keep a same day appointment could result in a charge of $39. This amount would not be billable to your insurance company and would be your responsibility.

10. **Appointments.** Please arrive 15 minutes prior to your appointment for established patient and 30 minutes prior to your appointment for new patients. If you are late for your appointment your provider will determine if he/she can still see you.

11. **Additional Questions**. If you have any questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company's member services department. The number for the department is listed on your insurance card.

By execution of this document, I represent that I have read this document carefully, understand the policies described in this document, and agree to comply with these policies and to fulfill my financial obligations with respect to the medical care provided by Southern Regional AHEC.

_____ _____

Printed Name & Signature of Patient or Responsible Party **Date**

_____ _____

Printed Name & Signature of Co-Responsible Party **Date**