# Financial Policy

**Insurance** – We participate in most insurance plans, including Medicare. If you do not have insurance or are not insured by a plan we do business with, payment in full is expected at the start of each visit. We do offer discounts to patients without insurance who will be paying cash for their services and this can be discussed with the office as necessary.

**Proof of Insurance** – All patients must complete our patient information paperwork prior to being seen by the physician. We must obtain a copy of a current photo ID and health insurance card. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of your claim.

**Co-payments and deductibles** – All co-payments and deductibles must be paid at the start of each visit. The collection of these payments 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.

**Insurance Claim Submission** – We will submit your claims and assist you in any way reasonable regarding the insurance claim process. In the event your insurance company requires more information directly from you, it is your responsibility to provide the requested information in a timely fashion to prevent any delays in claim processing. Please be aware that the balance of your claim is ultimately your responsibility, whether your insurance company pays the claim or not.

**Coverage Changes** – If your insurance changes, please notify us before your next visit so we may make the appropriate changes to help you receive your maximum benefits and process claims efficiently as noted above.

**Non-covered services** – Please be aware that some or all of the services you may receive may not be covered by Medicare or other insurances. You must pay for these services in full at the time of the visit. If you are insured by Medicare, an ABN (Advanced Beneficiary Notice) will be obtained.

**Payments** – We accept most credit/debit cards, cash, and personal checks as payment for services. In the event of a returned check, a **$25 fee** will be charged directly to you and is not reimbursable by insurance.

**Non-Payment of Account** – Any patient account that is more than 30 days overdue may be sent to collections for recuperation of payment. Payment plans are available and can be discussed with the office on a case-by-case basis.

## Assignment of Benefits

I hereby authorize and direct my insurance carrier with whom I have a policy, including Medicare, private insurance, and any other health/medical plan, to issue payment in electronic form or check directly to Dr. Michelle Bretzius and 302 Family Medicine, LLC for medical services rendered to myself and/or my dependents regardless of my insurance benefits. I understand that I am responsible for any amount not covered by my insurance. In the event my insurance provides payment for these services directly to me instead of my physician, I hereby agree to surrender such payment to Dr. Michelle Bretzius and 302 Family Medicine, LLC as payment for services rendered.

## Authorization to Release Information

I hereby authorize Dr. Michelle Bretzius and 302 Family Medicine, LLC to:

1) Release any information necessary to insurance carriers regarding my illness and treatments

2) Process insurance claims generated during the course of examination or treatment

3) Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

For more information regarding the type of information that may be released, please refer to our HIPAA Privacy Policy.

## Consent to Treat

I have requested medical services from Dr. Michelle Bretzius and 302 Family Medicine, LLC on behalf of myself and/or my dependents. Permission is hereby granted to all healthcare providers involved in my care to administer such examination, treatment, testing, and procedures that are deemed necessary in the course of my care.

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**Patient or Parent/Guardian Signature**                                    **Date**