Nell Klein, FNP-BC • Jessica Pilcher, ANP-BC • Sarah E. Bass, FNP-C

Legacy Health Clinic Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be included in your record and provided to you upon request.

1. Insurance: We are not participating providers for any insurance plans other than Medicare and Medicaid. As a courtesy, we will bill your insurance company provided we have a current copy of your insurance card. If you do not provide us with a current insurance card at the time of visit, payment in full is expected. Knowing your insurance benefit is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Proof of insurance: All patients must complete our patient information form before seeing the provider. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information at the time of your visit, payment will be expected in full.

3. Co-Payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. It is your responsibility to know your co-payment and deductible amounts. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. Telehealth and telephone consultations: The cost may not be covered by your health care insurance. You will be responsible for the bill.

5. Non-covered services: Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

6. Claim submissions: As a courtesy, we will submit your claim to your insurance provider and assist you in any way we reasonably can to help you get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company and we are not a part of that contract.

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7. Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

8. 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. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During the 30-day period, our providers will only treat you on an emergency basis.

9. We charge $25.00 for all non-sufficient fund checks.

10. Missed appointments: Our policy is to charge $25.00 for missed appointments not cancelled within 24 hours of your appointment. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your scheduled appointment.

Our practice is committed to providing the best treatment to our 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.

I have read and understand the payment policy and agree to abide by its guidelines:

____	___________________________
Signature of patient or responsible party	Date

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