HYPERTENSION & KIDNEY ASSOCIATES OF MIDDLE GEORGIA, LLC.
PAYMENT POLICY AS OF JAN 2014

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

Insurance Coverage

We will bill your health insurance carrier for services rendered by our providers, but it is your responsibility to make sure that we have your most current insurance information. If you change or add an insurance policy you must make our staff aware and present a new insurance card prior to your appointment. Any balances not paid by your insurance carrier are your responsibility and payment is due upon receipt of a "Billing Statement" or your next office visit, whichever occurs first. Also note, that Insurance Companies have agreements with certain laboratories, It is your responsibility to know which laboratory your insurance authorizes, and to inform the staff at Hypertension and Kidney.

Copays□We have a contractual obligation (with your insurance company) to **collect** your copay at the time of service, and you have a contractual obligation (with your insurance company) to **pay** your copay at the time of service. Because of these contractual obligations, **our office does not bill copays. Copays are the patient's responsibility and are due at the time of service.** We are considered specialty care by insurance carriers. If your insurance carrier has a specific copay amount for specialty care you will be expected to pay this amount at the time of service. If you are unable to pay your copay at the time of your appointment, we may require that you reschedule your appointment.

Accepted Forms of Payment

We accept payment by cash, check, Visa, MasterCard, and Discover.

Patient Outstanding Balances

If you have an outstanding balance with our company we will send a "Billing Statement" monthly to your home. We expect that you will pay your full balance upon receipt of our billing statement. If you are unable to pay the outstanding balance in full in a single payment, please contact our Billing Office. Our billing office is available Monday – Friday from 8:00am to 5:00pm to assist you in satisfying your financial obligation. Please call us to discuss payment plans, patient financial evaluations and discounts available..

Unpaid Accounts

In the event that you do not satisfy your account balance on a timely basis (defined as making a regular payment each month), we may elect to send your account to an outside collection agency. If your account is sent to an outside collection agency, we will add a collection fee to your account balance. The collection fee we charge you will be equal to the amount that the collection agency charges us. You will be responsible for paying the full balance, including this fee in order to continue receiving medical care from our physicians. Once your account has been sent to collections, you will need to make payment arrangements with the collection agency.

Other Possible Fees□Missed Appointment Fee - A missed appointment is a scheduled appointment that you miss without notifying us in advance. An appointment that is cancelled or rescheduled with less than 24 hours notice is also considered a missed appointment. Our policy is that the first time you miss or cancel an appointment with less than 24-hours notice, a letter will be sent to you. The 2nd time you miss or cancel an appointment with less than 24-hours notice a $25.00 fee will be charged to your account. Insurance companies do not cover this charge, and you will be responsible for paying this fee prior to being seen again by our physicians. **Disclaimer:** The missed appointment fee will not be charged if you missed your appointment because you were an inpatient in the hospital.

Returned Check Fee - It is the policy of Hypertension and Kidney Associates to charge $20.00 to patients whose checks are returned by our bank for non-sufficient funds. If a patient puts a stop payment on a check, the amount we will charge is $25.00. This is the amount our bank charges for these items.

Patient Name PRINTED: _____ **DOB:** _____

Patient Signature: _____ **Date**: _____