2020: Financial and Patient Responsibility

Aspen Family Medicine and Geriatrics is committed to providing the best treatment to our patients. To assist if your understanding of patient and insurance responsibility for services rendered, please review the payment policies below sign in the space provided.

Patient Responsibility: Patients should be aware of their benefit coverage including which physicians are contracted with their plan, covered and non-covered benefits, authorization requirements, and costs share information such as deductibles, co-insurance, and co pays. If you are not familiar with you plan coverage, we strongly recommend you contact your carrier directly

Insurance: We participate in most insurance plans, including Medicare. If you are **not** insured by a plan we are contracted with, payment in full is expected at each visit. If you are insured by a plan we are contracted with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.

Co-payments & 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. 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.

Proof of insurance: All patients must complete or verify their patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Non-covered services: Please be aware that some 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.

Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. In order to properly bill your insurance, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

Coverage changes: Please notify us prior to your next visit if your insurance changes. If your insurance company does not pay your claim in 60 days, we may contact you for assistance in securing payment.

Non-payment: Please be aware account balances over 90 days past due with no payment activity or patient communication may be subject to collections. Failure to secure payment arrangements could result in being discharged from the practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Account Balances: All past due balances are due at time of check-in. **Patients with balances over $100 need to secure payment arrangements with the Office Manager or Billing department prior to future appointments being scheduled.**

Billing Service: Aspen utilizes the billing services of **Medical Collections Consultants**. Please note, they are medical billers NOT a collections agency, despite collections being in their name. Please direct any questions regarding your bill or to make payment arrangements to 626-857-1019 or fax 626-857-1029

Consent For Treatment & Authorization to Release Information:

I, the undersigned, assign directly to **Aspen Family Medicine & Geriatrics** all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office to release all information to secure the payment of benefits. I authorize the use of my signature on all insurance submissions whether manual or electronic. I further authorize **Aspen Family Medicine & Geriatrics** to disclose information in my medical records, including current and previous medical records, to other physicians and health care providers to whom the physician refers me for my treatment. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Patient/Guarantor Signature _____ **Date**_____

10787 Laurel St. Rancho Cucamonga, CA 91730 Tel: (909) 982-7741 Fax: (909) 931-9568
www.AspenFamilyMedicine.org