Karibu Family Care

Financial Policies

Thank you for choosing us as your care provider. We are committed to providing you with quality and affordable healthcare. This billing process notification is developed to assist you with understanding your rights and responsibility when receiving services from Karibu Family Care.

Insurance: Karibu Family Care participates in many insurance plans, including Medicare. If you are not insured by a plan, payment in full is expected at each visit. If you are covered by a participating plan, but you are either missing an updated insurance card or you cannot provide policy and group number, you will be required to pay for your visit in full until our office is able to confirm your coverage. Knowing your insurance benefits and confirming that Karibu Family Care is a preferred provider in your individual network is **YOUR** responsibility, which can be done by calling the member services number on the back of your insurance card. Please contact your insurance company with any questions you may have regarding your coverage BEFORE your visit with Karibu Family Care, as we are unable to retroactively change billing/coding once a claim is processed.

Proof of Insurance: All patients must confirm and complete a patient information and consent to treat form before being seen. 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 in a timely manner, you will be responsible for the balance of the claim.

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 your insurers. You will be billed for these services and responsible for the remaining balance. It is **YOUR** responsibility to know which services are covered under your insurance benefits. Your insurance company may need you to supply certain information directly to process your coverage. Our staff will assist when possible, but ultimately it is your responsibility to comply with your insurers' request and confirm receipt of requested records.

Change in Insurance Plans: You are expected to notify our office **IMMEDIATELY** if your insurance coverage or plan changes to allow us to ensure we are still able to provide you with in-network coverage of your medical services. We will ask you to update your record at each visit to our office. Balances left over 30 days after processing by your expired insurance coverage will become the responsibility of the patient.

Claims Submission: We will submit your claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply certain information directly. It is YOUR responsibility to comply with their request. If payment is denied due to a lack of response from you, the balance will immediately become due and payable by you. Your insurance benefit is a contract between you and your insurance company. We are not party to the contract and are unable to verify each individual visit or diagnosis coverage. Insurance carriers give us a 90-day period to submit claims to them for payment. After that time, it will be denied as past timely filing. If we are unable to process your claim within that timeframe due to incorrect information given, we will bill you directly for our services.

Payment is Required at Time of Service: Patients who are not covered by health insurance, on a plan that we do not participate with, or if we are not able to verify your coverage must pay in full at the time of service. Patients who have plans that we do participate with are required to pay their copayment, coinsurance, and balances due for deductibles and non-covered services at the time of their visit. These dollar amounts are set by your insurer, **NOT** our practice, and as such are unable to be discounted after a claim has been processed. If a patient is unable to pay, the appointment will have to be rescheduled until balance is paid. For patients with high-deductible plans, a $25.00 deposit will be collected up front at each visit which will be applied towards your deductible until it is met in full. Any remaining balance set by your insurer will be invoiced in month-end statements. We encourage you to contact your insurer to know your total individual and family deductible and out of pocket maximum limits.

Self-Pay: We want to provide uninsured patients with quality and affordable healthcare. Most of our billed charges will be discounted for self-pay patients. For us to offer these rates, payments must be made in full at the time of service before leaving the office. No further discounts will be given. This discount does not apply if insurance is or has been billed. The self-pay discount does not apply to co-pays, deductibles, or non-covered services.

Outstanding Balances and Collections: Statements of balances due are issued monthly and are due immediately upon receipt. Should your account become 30 days delinquent, please be aware that your account will be sent to an outside collection agency. If your account does get sent to collections, the patient/guarantor will be responsible for and agrees to pay ALL costs of collection including attorney fees and collection fees of up to 33.3% of the outstanding balance. The contingency fees will be added to your outstanding balance and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

Third Party Billing: We do not do any third-party billing, follow-up or related activity. If a third party may be involved, it will be the patient's responsibility to seek reimbursement. Patients involved with a third-party payer will be expected to provide health insurance or if uninsured, will fall under the self-pay guidelines.

Minors: For all services rendered to minor patients, the parent or guardian who brings the patient to the appointment is responsible for all payments/balances due prior to the minor being seen.

No-Show/Late Appointments: To ensure our providers are able to offer consistent, timely, remarkable care to our patients, we have implemented a "no-show / late arrival" policy which will affect all patients who do not keep their scheduled appointment, arrive late for their scheduled appointment or who cancel an appointment with less than a 24-hour notice. All existing patients are required to arrive to the office 15 minutes prior to their scheduled appointment time to allow time for check in, verification of insurance coverage and signing of forms, new patients are required to arrive 30 minutes prior. Patients arriving after their scheduled appointment time will be charged a $40.00 no show fee and will be asked to reschedule to a different time/date. Subsequent no-shows/late arrivals will result in additional fees and may result in dismissal from the practice.

Our practices are committed to provide the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our financial policy. Please let us know if you have any questions.

Consent to Financial Agreement

You agree, in order for us to service your account or to collect any amounts you may owe, we or any of our representatives including, but not limited to, insurance, billing and/or collection agencies, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I have read this disclosure and agree that Karibu Family Care or any of its representatives may contact me as described above.

By signing your agreement, you acknowledge that this document serves as the only warning of the policies listed above, that all of your questions about the policies have been answered to your satisfaction, and that you agree to abide by its contents as part of your continued participation as a patient with Karibu Family Care, effective immediately. Failure to sign this document will be seen as a voluntary self-discharge from the practice, effective immediately.

Patient/Authorized Representative Signature: _____ Date:_____

Print Patient Name/Authorized Representative: _____

Karibu Family Care Staff Signature: _____ Date: _____

Print Name of Karibu Family Care Witness: _____