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Carolina Pilonidal Center Patient Financial Policy

Thank you for choosing Carolina Pilonidal Center as your health care provider. We are committed to providing you the best quality medical care. As a part of this relationship, we wish to establish our expectation of your financial responsibility. The following is a statement of our Financial Policy:

FULL PAYMENT OF PATIENT OBLIGATIONS IS DUE AT TIME OF SERVICE.

INSURANCE:

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to:

- Ensure our providers actively participate with your insurance carrier.
- Know your benefit coverage, as well as your dependents, prior to receiving services.
- Ensure that all pre-approval requirements are met to avoid denials or out-of-network benefits.

Please remember that we must receive your billing information at the time of each visit in order to meet claims submission requirements set by your insurance plan. If either the practice or the plan fails to receive accurate information to process your claim, you will be held responsible.

To summarize, your financial responsibility may include:

- Denied and Non-covered services or services deemed not medically necessary by your insurance company.
- Co-payments, deductibles, and co-insurance including non-Insurance and/or out-of-network benefits.
- Pended claims due to lack of patient and/or guarantor information.
- **In particular, the cleft lift procedure for pilonidal disease is partially covered by some insurance plans and in some cases is not covered by insurance as not medically necessary. You will be responsible for payment of any charges not covered by your insurance due to limits imposed on how many units can be used or if designated as medically not necessary.**

INITIAL HERE:_____

If you fail to receive an Explanation of Benefits (EOB) from your plan within 45 days of treatment, we suggest you contact your insurance plan, as they may not have made payment. Payment not received in 60 days from the date of service, may be transitioned to patient responsibility and you may be required to make other payment arrangements.
INITIAL HERE:_____

SELF PAY:

If you do not have insurance, you will be considered a “self-pay” patient. “Self-pay” patients will be given an estimate of what will be due before the visit. **Payment is required in full at the end of your visit and will be charged to your credit card on file.**

INITIAL HERE:_____

CO-PAYMENTS, DEDUCTIBLES AND CO-INSURANCE:

All co-pays, deductibles and co-insurance amounts (including out of network benefits) are collected at the time of service. This includes any amount due for surgery or in-office procedures. Our contract with your insurance requires us to collect these fees; we are unable to waive or write-off any co-pay, deductible or co-insurance. Failure to pay at check-in may result in your appointment, procedure or surgery being rescheduled or canceled.

INITIAL HERE:_____

DIVORCE DECREES/RULINGS:

In the case of services provided for minors, the individual who initiates services for the child will be responsible for payment. We will not bill another individual or estranged spouse for payment. Copayment is due at the time services are rendered. If the divorce decree requires the other parent to pay all or part of the treatment, it is the authorizing parent's responsibility to collect form the other parent. Carolina Pediatric Surgery will not act as a mediator in this effort.

INITIAL HERE:_____

SAME DAY CANCELLATIONS OR MISSED APPOINTMENTS/SURGERIES:

Unless canceled at least 24 hours in advance, our policy is to charge **$40.00** for missed appointments or same day cancellations. We cannot file nor will insurance pay for this charge. For surgery, we require a 5 business days notice of cancellation, failure to provide notice of surgery cancellation **2 weeks** in advance will result in a **$250 charge**.

INITIAL HERE:_____

RETURNED CHECKS:

Any returned checks will be charged an additional **$25.00** fee to be added to your account balance. This is in addition to any charges charged by your institution.

INITIAL HERE: _____

OUT OF POCKET EXPENSES:

Insurance companies do not cover miscellaneous supplies or administrative work.

- SUPPLIES: Any supplies you receive from our office must be paid in full at the time of service.
- MEDICAL RECORDS: We will be happy to furnish you with a copy of your medical records. You will need to request these in writing and a charge will be assessed based on time and volume.
- For FMLAs and other work related forms you will be charged a **$40.00 fee** per form.

INITIAL HERE: _____

COLLECTIONS:

Any past due balance not paid will be turned over to our outside collection agency after 90 days. In the event that the bill remains unpaid and litigation ensues for collection of sums due, this office shall be entitled to reasonable attorney fees and court costs. After 90 days, patient will be responsible for any unpaid balance including attorney fees accrued.

INITIAL HERE:_____

CREDIT CARD POLICY:

A credit card or debit card will be kept on file within our secure payment system. This card will be used to cover co-pays and/or co-insurance that is due based on your insurance benefits. This card will only be run with your consent. **Benefits will be checked prior to surgery and you will be notified of any deductible and co-insurance that you are responsible for. Payment will be expected before surgery.** Additional cards can be added at any time. If by the final billing notice (90 days), we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card after contacting you. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

INITIAL HERE: _____

FOR OUT-OF-NETWORK PATIENTS:

You are scheduled to receive care from Dr. George Wadie, MD, who is not in your health plan's network. You understand that this means you may be responsible for the full cost of the services, potentially exceeding your usual in-network cost-sharing. By signing below, you agree to receive care from Dr. George Wadie, MD and understand that you are waiving your rights to be protected from balance billing under the No Surprises Act. You may also be responsible for amounts that do not count toward your deductible or out-of-pocket maximum. You have been provided with a written notice explaining the estimated cost of services. You understand that you can refuse this service and receive care from an in-network provider instead. If you agree to these terms please initial and sign below.

INITIAL HERE: _____

Thank you for understanding our Financial Policy. Please let us know if you have any questions.

I have read and agree to this Financial Policy:

Patient Name and Date of Birth:_____ Name of Responsible Party: _____

Relationship: _____ Signature of Responsible Party: _____ Date: _____