**2016 FINANCIAL AND ADMINISTRATIVE POLICY**

**Midwest Nephrology Associates**

Please provide current insurance identification card (s) and valid identification at each visit.

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| **Your Health Plan** | **Patient Responsibility** | **Midwest Nephrology Responsibility** |
| Medicare | Pay your deductible ($166 for 2016) and co-insurance (20% of the allowable) at the time of service | We will file Medicare for you.  If you have a supplemental insurance, we will file for you. |
| Medicare and a secondary insurance | No payment due at time of service | We will file Medicare and your secondary insurance for you |
| Medicare and Medicaid | No payment due at time of service | We will file Medicare and Medicaid for you |
| Medicaid | Office visit copay | We will file Medicaid for you |
| Insurances we participate with | Pay your deductible, coinsurance, or copay at time of service | We will file your insurance for you |
| Non-Contracted Plans: insurances we are not participating with | Pay the visit in full at time of service | We will file your insurance for you and assign benefits to you so you will receive payment from your insurance plan |
| Self Pay\* | Pay the visit in full at time of service at discounted rate of current Medicare.  \*Payment plan available | None |
| Non-Covered Charges | All charges not covered by your insurance carrier will require payment in full at time of service or upon notice of insurance claim denial | We will file your health plan claim for you |

Other Fees:

Returned check - $35

No Show Repeat Fee - $40

**APPOINTMENTS**: If you need to cancel or reschedule your appointment, we ask you to kindly give us 24 hours’ notice.  We reserve the right to charge a $40 no show fee after repeated no show appointments.

**AGREEMENT TO PAYMENT POLICY**

I have reviewed and been given an opportunity to ask questions about the Financial and Administrative Policy and agree to the terms of payment due.

**AUTHORIZATION TO RELEASE INFORMATION**

I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to Midwest Nephrology Associates any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

**ASSIGNMENT OF BENEFITS**

I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Midwest Nephrology Associates for any services provided to me and/or my dependents.  I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

**GUARANTEE OF PAYMENT**

If my insurance has a contract with Midwest Nephrology Associates, I am not responsible for amounts the practice has agreed to write-off per the contract. If my insurance does not have a contract with Midwest Nephrology Associates, I agree to be responsible for any amounts not paid by my insurance plan. In the event that I default on payment of my account, I understand I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorney’s fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default. This does not apply to patients enrolled in traditional Medicare or Medicaid.

**WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

I hereby acknowledge that I have reviewed and had an opportunity to ask questions concerning the Notice of Privacy Practices of Midwest Nephrology Associates.

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Patient’s Name Printed                                                                 Patient’s Date of Birth

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Patient’s Signature                                                          Date

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Responsible Party Signature                                       Relationship to Patient