

Council Bluffs Surgical Associates, P.C.

Payment Policy

Thank you for choosing us as your general surgeons. We are committed to providing you with quality care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment arrangement are expected to be made at your visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, a payment is due at the visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments 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 from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered service.** Please be aware that some - and perhaps all - of the service you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must make payment arrangements for services at the time of the visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and 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.
5. **Claims submission.** We will submit your health insurance claims and assist you in any way we reasonably can help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim the balance will automatically be billed to you.
7. **Nonpayment.** Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from the practice. Our physicians will only be able to treat you on an emergency basis.
8. **Forms.** Fee of \$15.00 is due upon completion of Disability and/or Attending Physician Forms.
9. **Return Checks.** A \$45.00 service fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to prepay in full by Cash, Visa, MasterCard or Discover for additional services.
10. **Method of Payment.** We accept Cash, Checks/Debit, Visa, MasterCard and Discover. Payment plans may be arranged on an individual basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date