James E. Dowd, MD, PC
Board Certified Adult and Pediatric Rheumatologist
Board Certified Integrative Holistic Medicine

Patient Financial Policy

Thank you for choosing James E. Dowd, MD, PC as your rheumatology provider. We are committed to building a successful physician-patient relationship. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Please read the following financial policy thoroughly

Payment methods: Cash, Check, Visa, MasterCard

Insurance Billing:

- We participate with various insurances; we suggest that you always verify with your insurance carrier that you are covered for services at our practice.
- We will bill your insurance for services provided, however, it is our policy to collect **all co-pays, co-insurance and deductibles at the time of your visit.**
- We will verify your insurance before your appointment. The amount owed at your first visit will appear on the next page. Please be aware that the information on the next page was received directly from your insurance company. Unless the insurance company tells us differently, the payment will be expected at the time of service. If you disagree with this amount, please contact your insurance company.

Private Pay patients:

- Full payment of the office visit will be due at the time of the appointment. We apologize for any inconvenience, but we cannot accept a check at the first appointment; cash or credit card only.

Policy for Refund of Overpayment:

- It is our policy to refund overpayments to either the guarantor of an account or the insurance, in accordance to contract mandates. In order to make this process cost effective, no refunds will be issued to patients for amounts less than fifty dollars. Instead, this balance shall remain on the account until the patient presents again for service. However, patients at any time, can request for a refund of a credit balance on their account.

Collection Accounts:

- All past due accounts will be sent **two** statements. If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency and discharge from the practice will occur.
- All accounts more than 30 days past due will have a $5 monthly statement fee added to the account.
- In the rare case that an account is unpaid and it is necessary to send an account to a collection agency, you will be assessed a Collection Recovery Fee and will be responsible for any fees assessed by the collection agency (i.e.; attorney fees, court costs and collection agency fees).

*** We go out of our way to keep patient accounts from entering a collections status. Payment Arrangements can be made to assist in paying balances. Please contact our billing department for more information if needed. ***

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Missed Appointment / Short Notice Cancel Fees:

- If proper notice is not given, a fee of $35.00 will be assessed. (Please see New Patient information for cancellation policy)
- New Patients who "no-show" to their appointment and do not give proper notice, will not be rescheduled.
- Follow up patients who "no-show" twice, will be discharged from the practice permanently.
- Medical insurance does not pay for missed appointments. The patient will be billed charged personally for missed appointments.

Returned Checks:

- Returned checks will be assessed a $35.00 fee, in addition to the fees assessed by the bank. All returned checks will be submitted to the Livingston County Prosecutors office.

Verification of Insurance:

As a courtesy to you, we have contacted your insurance to verify coverage.

We have been informed by your insurance plan, you have:

☐ No office visit coverage ☐ A co-pay ☐ A deductible ☐ Please call your PCP for a Referral

A payment of: _____ will be due at the time of service

If you will be unable to make the payment above at the time of service, please call our office **before** your appointment to set up a payment arrangement.

By signing below, you agree to this Patient Financial Policy

_____ _____
Patient Signature (or Legally Authorized Individual) **Relationship to Patient**

_____ _____
Printed Name (if Signed on Behalf of Patient) **Date**

Medicare patients – Please read and sign below:

I request that payment of authorized Medicare benefits be made on my behalf to: James E. Dowd, MD, PC for any services furnished to me by their providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Printed Name (if Signed on Behalf of Patient) **Relationship to Patient**

_____ _____
Patient Signature (or Legally Authorized Individual) **Date**