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.

Please read the following financial policy thoroughly

Medicaid patients - verification of Insurance:

- Medicaid contracts are based on your **monthly** eligibility and cannot be verified until the month of your appointment. Please call our billing department directly, at: (810) 534-4486 the week of your appointment for eligibility information.
- If our verification determines you are not eligible for Medicaid benefits that month, our billing department will provide you the option of rescheduling your appointment or paying cash at the time of the visit.

Information changes: It is your responsibility to notify our office of any changes to your information (address, name, insurance information, etc.)

Payment methods: Cash, Check, Visa, MasterCard

Insurance Billing:

- We participate with various insurances; we strongly recommend you call the customer service number on the back of your card to verify you are covered for services at our practice.
- We will bill your insurance for services provided, however, we will collect **all co-pays, co-insurance and deductibles at the time of your visit.**

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. No refunds will be issued to patients for amounts less than twenty five dollars. Instead, this balance shall remain on the account until the patient presents again for service. However, patients at any time, can request 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 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. ***

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.

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.

All patients: By signing below, I agree to this Patient Financial Policy.

Medicare patients: In addition to my agreement to this Patient Financial Policy, 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 Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

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

_____ _____

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