

501 N. Frederick Avenue, Suite 304 Gaithersburg, MD 20877

(301) 330-3541

**Thank you for entrusting in *Foster Medical Care, LLC.* to be your healthcare provider**. We are committed to provide you with quality, efficient health care, and a developing patient/provider relationship. By complying to our Financial Policy Agreement, we can provide you with the best service. (*Compliance with this policy is* ***required*** *for all medical care*.)

With the exception of the information below, **PAYMENT IS REQUIRED AT THE TIME SERVICES ARE PROVIDED NO EXCEPTIONS!!** We accept cash, personal checks, VISA, MasterCard, Discover and American Express credit cards. There is a **$35.00** service charge for returned checks.

**INSURANCE**

We are pleased to bill your health insurance carrier as a courtesy to you. We accept assignments for Medicare and are participating providers for most HMO and PPO plans available on the East Coast. **Knowing your insurance benefits is your responsibility and you are responsible for any services not covered by your plan; that includes any coinsurance, copayments or deductibles that may be applicable:**

* ***Proof of Insurance*:** Any changes to patient insurance information must be updated to each office visit. You must provide valid and up-to-date proof of insurance coverage by providing a copy of your insurance card. If we are unable to verify your insurance or you do not have proof of insurance, FULL payment is due at the time of service. If payment is not received from your insurance carrier within our contract limits, any balance owed will be your responsibility.
* **Copayments and Deductibles:** All copayments and deductibles unsatisfied must be paid at the time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all required co-payments, co-insurances, deductibles and non-covered services.
* **Non-Covered Services:** Please be aware that many insurance plans (*including Medicare*) do not cover preventive health examinations (*i.e physicals)*. As a courtesy to you to bill your insurance carrier, you may be responsible for payment of this type of service, in full, if it is not covered by your policy.

**PATIENTS WITHOUT HEALTH INSURANCE**

Patients without health insurance are expected to pay in full for services at the time they are rendered. If you are unable to pay for services in full on the day of your visit, the remaining balance is expected upon receipt of your first statement. If you are unable to pay large balances with your own funds immediately, please seek financing through your bank or credit union. Other arrangements can be made, please see our Payment Arrangement section below.

**PAYMENT ARRANGEMENTS**

Foster Medical Care, LLC can, in certain circumstances of financial hardship, work out a payment plan for outstanding balances owed directly by the guarantor. We are happy to meet with you to discuss your situation and try to work out a plan that will meet both your needs and ours. Please call our office at (301) 330-3541.

**PATIENT/ GUARANTOR RESPONSIBILITY**

Our practice is committed to providing the best treatment to our patients while keeping our charges for administrative services at or the usual and customary charges of other medical practices in our area. You are responsible for payments regardless of any insurance company’s arbitrary determination of rates. All administrative fees must be paid prior to scheduling future appointments. You, as the patient also has a responsibility to:

1. Ensure that coverage is in effect at the time services are rendered.
2. Provide, at the time of your first visit and as soon as there are changes, the correct insurance company name, address, policy and group numbers and other information known only to the subscriber and/or patient that the insurance carrier needs to process the bill.
3. Pay any office visit copayment **at the time of your visit**.
4. Pay all balances due upon your receipt of your first statement indicating that an insurance carrier has:
5. Paid its share (***i.e. deductibles, co-insurance and over the usual & customary amounts are the guarantor’s responsibility***)
6. Denied a claim for any reason (*for example, if coverage was not in effect, the service wasn’t covered, etc.*)
7. Failed to respond to our sending the claim **for more than 60 days.**

***We will not under any circumstances falsify or change a diagnosis or symptom in order to convince a insurer to “pay” for care that is not covered, nor do we delete or change the content in the record that may prevent services from being considered covered.***

* **Appointment Cancellation, Rescheduling and No-Shows:** As a courtesy to other patients, we ask that you arrive on-time for your appointment. If you are running late, please give the office a call. After 15 minutes, you will be asked to reschedule your appointment. When you miss an appointment, it hinders other patients from being seen in our practice at a designated time. We required a 24-hour notice of cancellation to avoid a $40.00 cancellation fee for new patient appointment and a $25.00 cancellation fee for a Follow up appointment. **It is your responsibility to remember your appointment.**
* **Request for Copies of Medical Records:** You will be charged $22.88 Processing fee plus 0.76 per page for copies of medical records as per Medical Association, State and Federal regulations. These charges fall under administrative costs of copying and mailing such records.
* **Checks:** We will happily accept checks as a form of payment with two exceptions. No checks will be accepted from New Patients or and we do not accept starter checks. There is a $35.00 bounced check fee and you will lose your privilege to write checks to our office.
* **Co-payment and Co-insurance:** We are obligated to collect your co-payment at the time of your visit, **NO EXCEPTIONS**. If a situation arises and your co-payment is not paid at the time of service, your account may be assessed $10.00 for the cost of creating an invoice.
* **Filing Secondary Insurances:** We at Foster Medical Care, as a courtesy, will file secondary insurance claims. However, it is the patient’s responsibility to provide us with the necessary information to do so.
* **FMLA and other Disability Paperwork:** There is a charge of $50.00 per form, payable prior to these forms being completed. Please understand that is it our duty to ensure you receive your completed documents at a reasonable time. However, please understand that these forms are quite tedious and complicated. Please provide our office with the pertinent information to complete these forms without error. Please allow the office 7 business days to review the proper documents, complete it, copy or fax it.
* **Request for Mailing Medical Documents:** Requesting for any medical documents from our office to be mailed will result in a $10.00 mailing fee. Please allow any mailing request at least 3 business days before being sent out to recipient.
* **DOT Examination:** All DOT physicals are $90.00 with payment required at the time of appointment, regardless if you pass the exam or not. If you would like your DOT card may laminated.
* **Laboratory, Radiology and Other Diagnostic Service Bills:** Please make it your responsibility to check with your insurance company to verify what your schedule of benefits for any laboratory, x-ray or other diagnostic studies that may be ordered by the doctor during your visit. Any insurance claims or problems associated with an off-site laboratory must be dealt with through that facility or their billing agent.
* **Phone Appointments:** If you need to discuss a healthcare issue or abnormal test results. You will be asked to schedule an appointment to see the Doctor. Results take at least 3-5 business days or longer depending on the testing you had done. If you need to speak with the Doctor and cannot make it in for an appointment, a **phone consultation fee** of $25.00 will be assessed and added to your account.

**By signing this policy, you acknowledge that you have fully read and understand this agreement and are accepting primary financial responsibility for services rendered.**

**Patient’s Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Rev 4/23/18**