## Emir Primary Care Payment Modified Payment Policy for

**Clayton State University**

**Payment Policy**

**1. Insurance.** We participate in most insurance plans, including Medicare. If you are insured by a plan we do not do business with, a discounted payment of **$30.00** for each visit is required. 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/co-insurance and deductibles 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 and deductibles from patients can be considered fraud. I understand I have a copayment/office visit of $\_\_\_\_\_\_\_\_\_\_\_ and I am or am not prepared to pay such amount at this time. I am requesting you send the request for payment to the following parent(s)

Name of Parent(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Proof of insurance.** All patients must complete our patient information form before seeing the provider. 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.

**4. Claims submission.** We will submit your claims and assist you in any way we reasonably can to 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.** **You may be billed a co-payment or co-insurance based on the determination of the your insurance company. You are responsible for your co-insurance, co-payment or deductible.**

**6. Nonpayment.** If your account is over 14 days past due, will receive a letter stating that immediate payment to your account is due. Partial payments will not be accepted unless previously negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from receiving future services at **Emir Primary Care**

Thank you for understanding our payment policy. Please let us know if you have any questions.

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

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**Signature of patient or responsible party Date**

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