Office & Payment Policies

Office Policies

1. **Office Hours.** Our office hours: Monday 10 - 3, Tuesday 8 - 5, Wednesday 10 - 5, Thursday 8 - 5.

2. **Emergencies.** Please be aware that our office is not set up to handle emergency situations, nor are we available outside of business hours. If you are experiencing an emergency or are in crisis, call 911 or go to the nearest emergency department.

3. **Prescriptions.** All concerns are addressed at the time of appointment. Prescriptions are written so that the patient has enough of a supply of medication until their next scheduled follow-up visit. Therefore, patients should not need prescription refill requests between appointments.

4. **Cancellation Policy.** Our policy is to charge for missed appointments canceled with less than twenty-four hours notice. These charges will be your responsibility and billed directly to you. Patients with three missed appointments in a 12 month period will be considered for dismissal. Please help us to serve you better by keeping your regularly scheduled appointment.

Payment Policies

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments, deductibles, and co-insurance.** All co-payments and deductibles are due at th` e time of service. Co-insurance may be billed once your claim has been processed by your insurance company, however, OPC reserves the right to estimate this cost and collect at the time of service. Failure on our part to collect co-payments, deductibles and co-insurance from patients can be considered fraud. Please help us in upholding the law by paying your co-payment, deductibles, and co-insurance.

3. **Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be non covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.

4. **Out-of-network.** Please note that out-of-network coverage may result in higher costs to the patient.

(over)

Payment Policies (cont'd)

5. **Proof of insurance.** We must obtain a copy of your state issued photo identification and current valid 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.

6. **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. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **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.

8. **Nonpayment.** All accounts over 30 days are considered past due. Your account must be in good standing in order to see the provider. Partial payments will not be accepted unless otherwise negotiated.

9. **Uninsured or Self-Pay.** Uninsured patients or insured patients electing to pay out of pocket must pay at the time of service. You have the right to receive a "Good Faith Estimate" as a part of the No Surprise Act.

10. **Phone Calls.** All services performed outside of an appointment that require the attention of the provider will be billed to your insurance company. If you are uninsured or insured but electing to pay out of pocket, this charge will be billed to you directly. Payment is due upon receipt.

I have read and understand the office & payment policies and agree to abide by its guidelines.

Patient Signature: _____ Date: _____

Patient Name: _____

(If under 18)

Guarantor Name:_____ Guarantor DOB: _____

Guarantor Address:_____ City/State/Zip: _____

Guarantor Phone: _____