GRANITE STATE
FAMILY HEALTH

Our Financial Policy

You will be asked to provide your insurance card(s) at every visit. This is to ensure that the information we have is correct, and that your plan is current and one in which we participate. Out of date cards with incorrect information or the wrong insurance cards can cause unnecessary delays in the payment of your claim and the balance may ultimately become your full financial responsibility.

Frequently, small changes (for example, a group number change or plan change) may not be considered significant by patients, but insurers will not process claims that are not 100% accurate.

All office co-pays are to be paid at the time of service. **This is an insurance company policy**. If the co-pay is not paid at the time of service, you will be assessed a $5.00 late fee. We accept cash, check or credit cards.

We will submit insurance claims for our patients. However, the agreement of the insurance carrier to pay for medical care is a contract between **you** and the **carrier**. You should direct any questions and/or complaints regarding coverage to your insurance carrier, your employer (if in a group plan), or to your agent.

Insurances vary in their coverage, and it is the **patient's responsibility** to understand his/her medical benefits. There may be limitations and exclusions to coverage. The patient portion is set by the insurance company. Patients are responsible for any co-insurance, deductibles, and any other non-covered billable services. We do bill third parties such as secondary insurance, Workman's Compensation, Life Insurance, Disability Insurance, Accident Insurance, attorneys, etc. as a courtesy to our patients; however, it is sometimes our practice to also bill your primary insurance due to timely filing contracts and the likelihood that your third party is not going to pay us in a timely manner. It is the responsibility of the patient to satisfy any outstanding balances here. We will provide statements as proof of payment for patients to pursue reimbursement from the third party payer. If you do not wish to have these third party claims submitted to your primary insurance, you may obtain services outside of our practice. You can also choose to self pay for the services at the time of the visit and await reimbursement from the third party.

Payments

Balances are due upon receipt of statement. Bills for deductibles, co-insurance, and non-covered services will be issued after the insurance carrier pays its portion of the bill. If the balance remains unpaid after 30 days, a late charge may be applied to the account. We accept cash, checks and credit cards. In addition to paying through the mail, credit card information may also be called to office during normal business hours.

Medical Forms and Patient-Requested Letters

Charges to complete medical forms (driver's license, assisted living, insurance, etc.) and patient-requested letters **are not often covered by insurance and are therefore the responsibility of the patient**. Fees vary according to the length and complexity of the form or patient-requested letter and are determined by the provider. Please let us know if you need a quote.

GRANITE STATE FAMILY HEALTH

Annual Physicals - Your Insurance and Our Office

Many of the services provided in this office are covered and paid for by your insurance company.

Unfortunately, not all services are paid by insurance. In cases where the service has not been paid, you will be personally responsible for the bill. Before we bill you, we will make sure that all of the information provided to the insurance company is accurate and clearly describes the services you received.

INSURANCE FILING AND THE LAW

Federal laws addressing all insurance companies require that we submit claims to insurance company accurately, reporting the exact services performed and the exact reason for performing them. **We are not allowed to change this information just so an insurance company will pay the claim.**

Our practice is committed to these laws, and will submit claims to all insurance companies in this manner.

"ANNUAL EXAMINATIONS"

As a commitment to your health, we recommend that every patient have an "annual exam" that allows us to evaluate your overall health picture, and make sure you are not developing any unexpected problems or illnesses.

During this visit, we will update all of your known conditions, as well as look for any new problems. If additional complaints or medical problems are addressed during the physical examination, a second charge is generated for an established patient visit in addition to the physical. Unless there is some major new finding during this exam, we must submit the service to your insurance as an annual examination, which your insurance may not pay for. It is your responsibility to understand your insurance plan.

Along with the examination, the provider might suggest that some "screening" tests be done to allow her to get a better "picture" of your health. Your insurance company may also consider these services non-covered, and you will be expected to pay for them yourself. However, you may also have testing done for a chronic or acute condition in which your provider would need to order those tests under the chronic or acute diagnosis rather than a screening code. Again, we are committed to these laws and will submit claims to all insurance companies in this manner. It is your responsibility to understand your insurance plan.

Even if the results of these screening tests show some problem, we must submit them as "screening" to your insurance company, and cannot change the information on the claim just to receive payment for the services from the insurance company.

We will be glad to work with you on payment plans for non-covered services, but these arrangements must be made in advance.

Non-Covered Services Are Your Responsibility

Insurance companies do not pay for all medical services, even though it might be helpful to the patient. Each plan is different. Some high deductible plans only pay for a physical every year

and some plans like Medicare, only pay for a physical once in a lifetime. It is your responsibility to communicate your plan benefits to the provider at the time of the visit if your plan has specific requirements.

When a service is not covered by your insurance policy, you will be responsible for paying the bill.

We cannot change information on an insurance claim just so the claim will be paid.

If you are not sure if a service is covered by your plan, you will need to call your insurance company in advance to see if you are going to be responsible for payment.

Nurse Visits

Your insurance company likely considers nursing visits the same way they do an office visit with your provider, making you responsible for deductibles, co-pays, and co-insurance.

No Show Policy

- Due to an increasing number of patients who do not show for their appointments and who do not call in advance to cancel those appointments, we have been forced to institute a "No Show" policy which will take effect immediately. This policy does not apply to patients who call to cancel their appointment 24 or more hours in advance of the scheduled visit.

- After the first "No Show" the patient will be given a phone call and a friendly reminder that the office visit was missed.

- After the second and subsequent missed appointments a "no show" charge of twenty five dollars will be sent to the patient. This charge is not billable to the insurance company. It is due upon receipt. Failure to pay will result in discharge from the practice.

- Please note that we try to call and confirm appointments with our patients prior to each of their provider visits, however on rare occasions this may not be possible. Please do be certain to set yourself a reminder as most appointments are booked 14-366 days in advance.

Waivers

- **What is a Waiver?:** When you come for your first office visit, you will be asked to sign a form (the waiver) that states you are accepting financial responsibility for "any charges incurred from services rendered" during any office visit which are not covered by your insurance company.

- **Why do I need to sign the waiver?:** Many insurance companies, including Medicare, are denying payments to physicians for office visits, procedures, and/or testing which they (the insurance companies and Medicare) feel are either routine or for health screening purposes. They may also deny payment for medical services and blood tests which they feel are not "reasonable or necessary" even though your provider feels that they are reasonable and medically necessary. In order for us to recover our costs of providing service, we require that you sign a waiver. If you refuse to sign, we will be

unable to see you for anything other than emergency or very urgent medical services since we do not know prior to receiving payment from your insurance company what services they will and will not pay for. If you are not willing to sign the form, we do retain the right to discharge you from the practice.

- **How do I know if I will have to pay for non-covered services?:** You may or may not be expected to pay at the time of service for non-covered services. If payment was not collected at the time of service, you will receive a bill for non-covered services after your insurance company and any applicable co-insurance company has denied payment. All invoices are due in full upon receipt.

"Helpful Insurance Hints"

- If your employer is self-insured and uses a third party to administer it's health benefits (a TPA), your claim will not be paid until your employer releases the money to the TPA. If we have not received payment from the TPA after a reasonable period of time, we will contact you about the matter and have you talk to your employer about resolving this problem.

- Always show us your most recent insurance card at the time of your office visit so that we can be sure we are billing the correct insurance company.

- Do not cancel your old insurance unless you have verification of your new insurance. KEEP YOUR OLD CARD FOR APPROXIMATELY ONE YEAR. That way if an old charge is still lingering unpaid you have the information you will need to get reimbursed for the claim.

- The first of the year many businesses change insurance companies. Most of these companies are not able to issue new insurance cards immediately. If you obtain the following information from your new insurance company we can bill your claim without your insurance card:

    - Employee's name and date of birth
    - Name of insurance company
    - Mailing address for medical claims
    - Payer ID
    - Group number and name of employer
    - Policy ID number
    - 1-800 number for providers to call to check status of claim

- **If you are unable to provide all of the information in full, we will bill to self pay and you can submit to the insurance company for reimbursement.**

- Make sure your insurance company has your correct primary care provider (PCP) listed. If you see us, and another PCP is listed on your insurance card, the claim may not be

paid at all, or will be paid as "out of network" at a higher cost to you. If you are uncertain which provider is PCP, then simply request that they list Wendy Wright, APRN.

- Remember, if you have yearly deductibles with your insurance most are payable beginning January of every new year. Check with your insurance company to see when your year begins in case it is not a "calendar" year. Please plan ahead financially as the deductibles are increasing across the board.

- If you are required by your insurance company to sign a claim form each year, contact your union representative or insurance company and have them send it to you.

- If you have a dependent in college, most insurance companies will request copies of their class schedule for each term in order to determine eligibility. Please go on-line and take care of this each semester so as to avoid any claims being turned over to self-pay.

- If you change insurance companies, be sure to give us a copy of your new card, even if you haven't come in to see us, because we will need your most recent insurance information if we have to prepare a referral to a specialist or prior authorize a medication.

- If you change insurance companies you will receive a certificate of coverage letter from your old insurance company stating your coverage dates. Give a copy of this to your new insurance company, as this will in some cases help you get a waiver for pre-existing health problems.

- If you have a lapse in coverage when switching from one insurance company to another, check with the new insurance company to see what the time period is for covering pre-existing illnesses, and how far back they will check your medical records to establish a pre-existing illness.

- Before seeing any specialist, make sure the referral form (if one is required) has been completed. You may not have received confirmation of approval from your insurance company by the time of your visit, but the specialist should have received it. Alternatively, we will have a "confirmation number" from the insurance company authorizing the referral in your chart. Please note that due to the large volume of referrals, we cannot guarantee timely processing of referrals requested less than 48 hours prior to the visit with the specialist.

- If you are away from home and need urgent or emergency care, please contact us during business hours so that we can place any needed referrals. We are unable to authorize referrals after hours since the insurance companies themselves are closed. You should also contact your insurance company directly to be sure they don't have any other requirements. Please be aware that a valid referral from us will not guarantee payment of the urgent or emergency visit, as the insurance company may determine after your visit that it was not a medical emergency or that the services were not provided by a covered facility. Please be certain to have the name, address, tax identification number and National Provider Identification number.

- Some insurance companies contract with providers all over the United States, and some contract only with your local state providers. To avoid having to pay "out of

network" costs, always use providers within the network established by your insurance company.

- Some office visits and physical exams are not paid as a covered benefit. If you do not have "routine coverage" anything that is billed as routine (e.g., annual exams or "well visits") or prevention (e.g., routine vaccinations) will be denied for payment. Check with your insurance company to see if you have routine benefits or not. This is exactly the opposite with some of the newer high deductible plans. Please be certain to know and understand your plan.

- If your insurance policy has psychiatric benefits, these may be paid in a different manner than routine office visits, even if the psychiatric service is provided by your primary care provider and not a psychiatrist. Some insurance companies pay only 50% of the charge. Sometimes only medication management is paid if you see your primary care physician. Also keep in mind that some insurance companies consider depression, anxiety, attention deficit, etc to be psychiatric diagnoses even though your primary care provider treats you for these conditions. When in doubt, check with your insurance company to see how they handle psychiatric claims both by your primary care provider and by your psychiatrist.

- If your insurance company has requested accident or other medical information from you be sure they have received the information you provided them, have passed it on to their processing department, and have released the claim for payment. Be sure one hand knows what the other hand is doing.

- We receive many phone calls about laboratory bills. We do not run our own lab but rather, as a convenience to our patients, have a satellite office on site. They in turn bill the insurance company, and if the claim is not paid, send the unpaid bill to you. You need to let the lab technician know what your current insurance coverage is at the time she draws your blood so they lab contractor can bill the correct insurance company. If the lab makes a mistake nonetheless, tell them to re-bill the correct insurance company.

- Many insurance companies will not pay for tests which they feel are "not medically necessary" even if your provider feels they are because each insurance company has it's own definition of "medically necessary". Likewise, some insurance companies will not pay for "routine" lab tests, and will require a medical diagnosis for each and every test that is done. If the lab test is done for a specific diagnosis, but is billed as routine, ask the office staff for a letter of explanation from your provider so that you can send in an appeal to the insurance company for their consideration.

- If you have a secondary insurance, please be certain to communicate this to your primary insurance especially if you have Medicare so that they can automatically forward the claim to the secondary carrier. If this is the case, you will need to contact them at the beginning of each year to update them whether or not there have been changes.

- If you receive a request for information from your insurance company, please complete and return the request immediately. Delay in payment from the insurance company may result in a transfer of responsibility from the insurance company to self-payment.