

**Michael T Havig MD PL**

**FINANCIAL POLICY**

*Thank you for choosing us as your health care provider. We are committed to serving you to the best of our ability. In order to bring you the quality of service, which you expect, we need to reach a mutual understanding about our payment policies. We therefore ask you to read and accept the following statement of our financial policy prior to treatment.*

**I. PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE.** We accept cash, checks, and Visa, MasterCard, and American Express.

**PRIVATE INSURANCE**

Your insurance policy is a contract between you and your carrier. We are not a party to that contract. You are responsible to know the policy of the company that insures you. This includes obtaining any referrals from your primary care provider before coming to see our physicians. Your bill with the physician is your responsibility whether or not your insurance company pays for the services rendered. You will be asked to pay only the co-pay and your unmet deductible at the time of your visit. If your insurance company has not paid your account within 90 (ninety) days, the balance will automatically become due from you. We stress that the correct insurance policy information be provided for billing. Claims denied due to terminated policies, unidentifiable policy numbers, or wrong billing addresses will become the patient’s responsibility This is due to the limited amount of time required by insurance companies to file a claim.

Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care. We assure you that what we charge you is usual and customary for our area. If your insurance company refuses to accept the level of our charge, unfortunately, we must still hold you primarily responsible for payment in full.

**MANAGED CARE CONTRACTS**

We currently participate in some “managed care” insurance programs. If you are covered by one of these identified programs, you will be required to pay any co-pay, unmet deductible or non-covered service at the time of each visit. Make sure you present your identification card to the receptionist and advised that you are covered under a managed care program. As with any other insurance policy, if your managed care administrator has not paid your account within 90 (ninety) days, the balance will automatically become due from you.

**MEDICARE PATIENTS**

We are participating physicians with Medicare. This means that you will only be responsible for 20% of the approved Medicare fee, the \$131 yearly deductible and full payment of any non-covered services. Non-covered services include but are not limited to complete annual physicals, immunizations and diagnostic tests done for screening purposes.

Supplemental insurance is available to cover all charges that Medicare does not pay. Medicare submits claims directly to some supplemental insurance carriers including those connected to their Medicap program. We will file claims with other supplemental insurance carriers that pay the physician directly. Otherwise, you will be required to pay the 20% co-payment, unmet deductible or non-covered service at the time of each visit and then file your claim with your supplemental carrier. Medicare HMO participants need to obtain a referral when out of network or denied services will become your responsibility.

**MEDICAID**

Medicaid patients over 18 are required to pay a \$2.00 co-pay at the time of their office visit (plus \$1.00 per each diagnostic test). If you have a Medipass provider, your service will need to be verified with that provider prior to treatment. If we cannot obtain an authorization from your Medipass provider, you will be responsible in full when service is rendered.

**PATIENTS UNDER THE AGE OF 18**

A parent or guardian must accompany the child who will be responsible for payment of the bill at the time of service. We cannot be bound by any divorce or other family relationship contracts. Any account 90 days past due will be turned over to an outside collection agency and you will be responsible for ALL costs of collection in addition to unpaid charges. A typical collection fee is 40% of the charges.

**ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electric.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. \_\_\_\_\_ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature that payments be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Beneficiary Signature

\_\_\_\_\_  
Date