Partners in Internal Medicine
Financial Policy & Patient Responsibility Notice

We consider payment of services to be the responsibility of the patient in the patient-physician relationship. Therefore, we would like to explain our payment policy and patient responsibility expectations to ensure your understanding and compliance. First and foremost, it is expected that you provide our office with the most up to date information about you (contact info, insurance coverage, etc.) at every single visit. Partners in Internal Medicine (PIIM), provides many types of medical services within our practice. There are many insurance companies (each offering several different plans or policies) so we at PIIM cannot know whether a specific service is covered by a particular plan or policy. Stated otherwise, it is impossible for PIIM to know the different group benefits from one employer or individual plan to the next. Our staff will make every effort to assist you in understanding your health benefits, although we are not responsible for knowing/informing you what services are covered by your particular health plan.

For the insurance carriers we do participate with, we will file on your behalf directly for payment. Please see www.piim.org for the list of contracted insurances, or ask a member of our staff. **Insurance co-payments and non-covered services are expected to be paid in full at the time of service. PIIM accepts cash, checks, and all major credit cards.** Additional amounts may be due at a later date, after we have billed your participating insurance (i.e. coinsurance, deductible, uncovered services).

If you are covered by a **commercial insurance plan** that we do not participate with, you are expected to make full payment at the time of service/treatment. Upon receipt of full payment, as a courtesy we will submit your claim to your insurance carrier and a refund will be mailed to you for any reimbursement we may receive from the insurance company. If you are unable to make payment in full, we will be unable to provide this courtesy to you. If you have no insurance coverage, payment in full is expected at the time of your visit.

NEW FOR 2014 (Affordable Care Act):
If we are unable to verify eligibility with your insurance company for any reason (i.e. non-payment of marketplace premium), you will be expected to pay for all services in full the day of your visit. We will attempt to bill the insurance and a refund will be mailed to you for any reimbursement we may receive from the insurance company.

Consequences for non-payment/defaulting on payment of amounts due to PIIM:
1. Failure to pay copay, deductible, or other fee due at time of service = $20.00 additional processing fee (see description of fee below)
2. Unpaid balance after 3 statements mailed to you = balance forward to pre-collections for additional collection communications (TransWorld Systems Inc.)
3. Unpaid balance after additional 70 days = balance referred for complete collections (i.e. credit agency reporting) with TransWorld Systems, Inc. Accounts deemed delinquent are subject to collection costs and possible dismissal from our practice.

Additional Practice Related Fees:

- **$50.00 Fee** = "NO SHOWS" (failure to provide cancellation notice) prior to your scheduled appointment.
- **$35.00 Fee** = Returned checks for non-sufficient funds. We will not accept any personal checks until account balance and associated services fees are paid in full. If this is a repeated occurrence, we will only accept cash or credit card as method of payment.
- **$20.00 Fee (NEW)** = Time of Service/Processing Fee: Additional fee for failure to pay your copay, deductible, or other amount due on the date of your visit.

By signing below, I acknowledge and understand the Financial Policy of Partners in Internal Medicine, I agree to the terms of payment due, and accept all payment terms under this Policy. I understand my responsibilities as a patient to know and understand my health insurance benefits for services provided and agree to pay all applicable charges which are not paid in full by my insurance.

_____ _____
Signature of Patient or Person Responsible for Account Date

_____ _____
Office Staff – Witness Date