FINANCIAL POLICY

In today's financial climate, we understand that patients must be efficient with their money and that you, as a patient and a consumer, have options in healthcare. In order to help keep your costs down, we are making a concerted effort to run as financially efficient of an office as we possibly can. In order to do this, we strictly abide by the following guidelines. If you have any questions please call our office at (740) 687-8600.

Patient Name: ____ DOB: ____________________

1. **PAYMENT**

Payment is due at the time services are rendered. Our staff will provide you with as accurate information as available to us from your insurance company regarding your copay, deductibles, and coinsurance amounts. Balances that are residual after filing with your insurance company will be expected prior to your next scheduled office visit or statement date, whichever is sooner. If the patient is unable to pay at the time of service, the appointment will be rescheduled. We accept cash, check, or credit card.

2. **NO SHOW POLICY**

If you are unable to keep a scheduled appointment, please let us know 24 hours in advance. A **NO SHOW** is when a patient fails to keep a scheduled appointment. A no show will generate a $25.00 fee that will **NOT** be billed to the patient's insurance company and could result in being discharged from the practice at the physician's discretion. This fee must be paid before any further appointments will be scheduled. Failure to pay the no show appointment fee will require that you seek your medical care elsewhere. We do send out reminder calls prior to each appointment. You can also opt in to receive text message reminders for appointments. Please ensure we have your correct contact information.

3. **FEES**

NO SHOW- $25.00
Forms- $10.00 Processing time is 7-10 business days once payment is received
Returned check- $25.00 -We do not rerun any returned checks through the bank.
Medical Records-

- First 10 pages $3.07 per page
- Pages 11-50 $0.64 per page
- Pages 51 & higher $0.26 per page

4. DEFAULT

Should you default on your balance, Fairfield Medical Associates has the right to discharge you as a patient and not accept new diagnosis. If your account qualifies for collection, you will be assessed all collection and/or legal costs. You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address that you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable. If you are set up on a payment plan and miss a payment we reserve the right to discharge you from the practice and turn refer the account to collections. You must pay the full designated payment amount each month to remain in the practice and avoid collections.

5. SELF-PAY/UNINSURED

Self-pay/uninsured patients do receive a discounted rate. This is calculated off of Medicare allowables. You are expected to provide a credit card, blank check or $50.00 cash deposit prior to seeing the physician in order to secure payment for the service rendered. Once the appointment is over you have the option to pay the total due at a 20% discount or the option to be billed the total amount without the discount minus the $50.00 deposit. The total must be paid at the end of the visit on that day to receive the discount.

6. INSURANCE & INSURANCE CARDS

We require to see your insurance card at **EVERY** visit and you may be asked to reschedule your appointment if it is not present. You will be responsible for promptly responding to your insurance company to provide any additional information they may request regarding your treatment, pre-existing conditions, coordination of benefits, accidents, or prior medical coverage. Your insurance company may need you to supply certain information directly. **If you fail to notify us or your insurance company of a change within 60 days, most insurance companies will consider this to be past timely filing and will not process your claims for the visit and the balance will become your responsibility.** Our office participates with and will bill directly to Medicare and, as a courtesy to you, we will also file a claim with your secondary insurance if we are provided a copy of the secondary insurance card. It is also the patient's responsibility to verify all coverage and costs with the insurance company prior to all visits. If you are asked to reschedule your appointment the visit will be considered a no show which may result in a $25.00 no show fee.

7. PERSONAL INJURY/AUTO ACCIDENT

It is your responsibility to inform registration that you are being seen due to a personal injury or auto accident. You must provide the date of accident and state. Commercial insurance will be billed if applicable and any remaining balance that is not paid by insurance is patient responsibility. We will provide you with an itemized statement for your insurance, if needed. Please remember that you are ultimately responsible for payment of your bills, not your attorney.

8. **WORKER'S COMPENSATION**

Fairfield Medical Associates physicians **DO NOT** provide care for worker's compensation cases. Please contact the local BWC office at (800) 385-5607 for names of BWC providers.

9. **FORMS**

All FMLA forms require an appointment as well as any other forms at the physician's discretion. All other forms will that require completion need to be present during your appointment. If any form requires completion outside of your appointment there is a $10.00 fee that must be paid prior to paperwork completion. All appropriate fields must be completed by the patient before physician will complete. **Processing time is 7-10 business days**. Patients are responsible for providing current legal documents to input into the patient's chart or to replace existing paperwork and notifying our office of any custodial changes, etc. All legal documents must be replaced by legal documents unless that legal document has an expiration date.

10. **MINORS**

Individuals that are not the parent or legal guardian arriving with minors to be treated will be re-scheduled if the Designation to Consent for Treatment of a Minor form has not been completed with the adult attending the appointment listed. The patient's co-pay is also due at the time of service. These forms are available on our website or our office. Any minor arriving to his or her appointment alone must have a completed minor consent form from the parent or legal guardian giving consent for treatment. If there is no form, we must receive verbal consent from the parent or legal guardian before the patient can be seen. If no contact can be made the appointment will be re-scheduled. If you are asked to reschedule your appointment the visit will be considered a no show which may result in a $25.00 no show fee.

Both parents shall have the right to obtain health information regarding their minor child. Ohio law defines minor child as any individual under the age of eighteen (18) years old. See Ohio Revised Code §3109.01 and 2151.011. This policy will apply irrespective of which parent completed the patient intake forms. Unless the situation is deemed an emergency, the requesting parents shall first complete an authorization to disclose the health information in order to have access to the minor's records, in compliance with Federal and State laws. Our office will verify a parent's identity with the information provided to us prior to releasing health information regarding the child.

In the case of divorced parents, each parent will similarly have access to their child's health information, pursuant to Ohio Revised Code §3109.051. A parent of a child who is not the residential parent is entitled to access under the same terms and conditions under which access to health information is provided to the residential parent, unless an Ohio court has determined that the non-residential parent of the child should not have access to the child's records under the same terms and conditions. In the event that an Ohio court has determined that the non-residential parent should not have the same access to the child's records, the residential parent **MUST** make Fairfield Medical Associates aware of the determination by providing a file stamped copy of this Court's Judgement Entry, in order to limit the non-residential parent's access to the child's records. If Fairfield Medical Associates is not made aware of such a determination, even if such court determination exists, equal access will be granted to the child's medical records.

Minor's Health information will only be released to the following individuals pursuant to Ohio Revised Code §3701.74: the minor's parents or other person acting in loco parents (meaning an adult who is the caretaker of the minor, who is charged with the rights, duties, and responsibilities of a parent): a court- appointed guardian; a person with durable power of attorney for health care for a patient (not applicable to a minor); the executor of administrator of the patient's estate; or the person responsible for the patient's estate if it is not to be probated unless consents are given to release information to anyone other than the parents in the child's medical record. **It is the parent or guardian's responsibility to keep consent information updated with Fairfield Medical Associates.**

11. **DIVORCE**

Payments including but not limited to copays, deductibles, coinsurance or any additional fees charged by your insurance are due at the time of service regardless of which parent is responsible for medical expenses. We are not a party to your divorce and/or separation agreement. We will first attempt to collect payment due from the parent who brings the child to the visit. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Both parents will be considered equally responsible for payment and will be jointly and severally liable. This will apply regardless of the terms of the parties' divorce decree. It will be up to the parent(s) to resolve divorce decree differences. Should the parents fail to pay for services rendered, the provisions of section 4 (Default) of this policy will apply.

12. **PHOTO ID**

A valid photo ID is required at **EVERY** visit to verify the patient. The ID will be scanned into the chart until expiration but will be checked at each visit. Failure to provide a valid photo ID could result in the appointment being re-scheduled and the visit being considered a no show which may result in a $25.00 no show fee.

13. **AFTER HOURS & WEEKEND APPOINTMENTS**

After hours appointments begin at 5:00 p.m. and weekend appointments are available. There is an additional fee for these appointments and will be billed to your insurance. The patient is financially responsible for any remaining balance for an after-hours or weekend appointment.

14. **PAYMENT PLANS**

Payment plans are available at Fairfield Medical Associates and are required for any balance over $200.00 that is not being paid in full. Payment plans can only be set up for balances $200.00 and higher. These are interest free plans that allow our patients to pay down the balance each month. Payments for plans are decided by taking the balance and dividing that by how many months are required based on the tier. All payment plans require that a credit or debit card be placed on file and auto deducted each month. Patients are only permitted one payment plan per patient at one time and any balances one incurs outside of the payment plan must be paid in full before any additional appointments will be made. Each patient must sign a Payment Plan Agreement which will be kept on file. If the card on file is declined Fairfield

Medical Associates will make two attempts to make contact for new card information and if no contact is made the account will be turned over to collections and the patient will be dismissed from the practice. Refusing to sign up for a payment plan will require the full balance to be paid before any additional appointments can be made. All payment plans are set up at the discretion of Fairfield Medical Associates.

Balance Tiers

- Balances $200-$499 must be paid within 4 months
- Balances $500-$999 must be paid within 8 months
- Balances $1,000 or higher must be paid within 12 months

15. **INJECTIONS/VACCINE(S)**

We understand that injections/vaccines can be uncomfortable for some patients but for the safety of our staff and the safety of our patients we will not restrain any patient for any injection/vaccine(s). The parent or guardian is responsible for restraining the patient for the injection(s). **If our staff determine that the situation is unsafe and they are unable to give the injection(s)/vaccine(s) the patient will be responsible for the cost of the unused vaccine(s) and this will NOT be billed to the insurance**. Fairfield Medical Associates reserves the right to refuse any patient any injection/vaccine(s) if they feel the situation is unsafe for all parties involved.

16. **ANNUAL PHYSICAL EXAMS**

Annual physical (well exams) target preventative care and are billed as such. Other ailments, injuries, or illnesses found and addressed during an annual physical exam are billed **IN ADDITION** to the annual physical and may bring additional charges. Certain insurance plans also may only allow one annual exam per calendar year, additional visits that insurance does not cover will be passed onto patient responsibility so please check with your insurance before scheduling your annual visit.

17. **PREGNANT PATIENTS**

Fairfield Medical Associates does not provide care to pregnant patients. We will confirm a pregnancy and refer to an OBGYN but once a pregnancy is confirmed FMA will refer **ALL** medical care to the OBGYN. If you are pregnant or there is a chance you might be pregnant you are **REQUIRED** to let our staff know.

I HAVE READ ALL OF THE ABOVE STATEMENTS AND I AGREE TO THE TERMS OF THIS AGREEMENT. I HAVE READ THE DISCLOSURE AND AGREE THAT THE LENDOR/CREDITOR MAY CONTACT ME AS DESCRIBED IN SECTION 4. I UNDERSTAND THAT REFUSAL TO WORK WITH FAIRFIELD MEDICAL ASSOCIATES REGARDING PAYMENT OF BALANCES WILL RESULT IN DISMISSAL FROM THE PRACTICE. I UNDERSTAND THAT REFUSAL TO SIGN THIS DOCUMENT WILL RESULT IN DISMISSAL.

SIGNATURE: ______________________________ Date: ______________________