DIABETES & THYROID CARE

OFFICE POLICY AND PROCEDURES

Confirmation, Timely Arrival and Cancellation. Our office staff tried to accommodate your schedule when offering appointment dates and times. We confirm your appointment at least 48 hours prior to the visit. **If no confirmation is made by either phone, text message or email, the appointment will be cancelled**. If you must cancel your appointment, please kindly provide us with at least 24 business hours' notice. **If we do not receive your notice to cancel the appointment at least 24 hours in advance, a $50.00 no show fee will be charged to your account.**

Prior authorization of medications. Prior authorization of medications will not be automatically obtained. If a medication prescribed to you requires a prior authorization, you are responsible for contacting your insurance and requesting the name of the alternative preferred drug covered under your insurance and notifying the office so a new prescription can be issued. **If prior authorization must be obtained a $50.00 processing fee will be required before starting the process. If the prior authorization is denied by your insurance company and you request to appeal against this decision, a $100.00 processing fee will be required before starting the process.**

Completion of medical forms: Letters, medical forms, jury duty excuses, patient assistance program forms, parking permits, FMLA forms and any other documents requiring physician review and completion will have a processing fee associated with it and payment of such fee will be required before starting the process. Please contact the office for the specific cost of the requested service.

Payment Options. Our office accepts payments by credit cards, checks and cash for the services rendered. Payment is due on the day of service. If you need an itemized bill, we can provide it after the visit at your request.

Insurance Information. We accept most insurance plans; however, we cannot guarantee that services provided to you will be reimbursed by your health insurance. If the doctor participates with your insurance company, we will make sure that the information submitted to the insurance company is accurate and clearly describes the services that you have received during the office visit. **You must provide a valid insurance card at the time of the visit. When applicable, the patient is responsible for all co-payments, deductibles or co-insurance amounts at the time services are rendered**. If your carrier denies coverage for a claim, you will be responsible for the balance, subject only to any restrictions imposed by law or contract. If our office does not participate with your insurance company, you must make payment in full at the time services are rendered with no exceptions. Our office does not submit claims to secondary insurance if the secondary insurance does not accept electronic claims. You should call your secondary insurance carrier and set up "automatic crossover" so that your primary insurance company sends your claim directly to your secondary insurance company. **Patients with Medicare as their primary insurance should call 1-800-633-4227 to determine if they are already set up for automatic crossover.**

Payment Policies. Any balance for non-covered services are due within 30 days of the insurance payment or denial and will become your responsibility. Any balances that remain unpaid after 90 days from the service date, and are not subject to payment arrangements, the account will be evaluated and turned over to a collection agency or attorney for handling. If your account is turned over to a collection's agency, you will be responsible for any fees imposed by the collections agency to collect your account. As these fees can be in excess of fifty percent (50%) of the outstanding balance, please be sure to pay your balance promptly.

Diabetes & Thyroid Care reserves the right to change the office policy and procedures at any time and without notification. An updated form will be available upon your request.

Certification I have acknowledged that I have read and fully understand the above financial office policy. I understand and fully accept the terms herein. I agree that a photocopy of this agreement shall be valid as the original. This authorization shall remain valid until revoked in writing.

Signature of Patient/Patient's representative	Printed name of person signing	Date

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