

Payment Policy for Seacoast General Surgery, PC

Thank you for choosing us as your General Surgeons. We are committed to providing you with quality and affordable health care. Below we have listed our Payment Policy. Please read it, ask us any questions you may have and sign in the space provided.

Insurance: We participate with many insurance plans. All patients must complete our patient registration form before seeing the doctor. We must obtain a copy of your current valid insurance ID card to provide proof of insurance, along with a picture ID to verify who you are. Please be advised we confirm insurance coverage and ask to see your insurance ID card at each visit.

Insurance Companies we are current participating with

Aetna, Anthem, Cigna, Harvard Pilgrim, First Health/Coventry, MVP, Medicare, NH Medicaid, NH Healthy Kids, Three Rivers Network and United Healthcare

Co-Payment: All copayments must be paid at time of service. This arrangement is part of your contract with your insurance company. Failure on our part of collecting co-payments from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

Failure to pay at time of service will result in a handling fee of \$10 above your customary co-payment amount.

Private Pay Patients: If you do not have insurance or are covered by an insurance we do not participate with, we will ask for a **DEPOSIT** of \$150.00 at time of service depending on the type of visit. You will be billed additional fees, if applicable, at a later date. For your convenience we accept personal checks, cash, and credit and debit cards. Payment in full we be expected within 20 days of receipt of your statement. If your bill exceeds \$200.00 a payment plan can be worked out. Please contact any office staff employee at 603 749 2266 and they will document a payment plan.

Custodial Parents: If you are the custodial parent, by law you are responsible for payment of your child’s medical bills, even if you are not the carrier of your child’s insurance policy. Our agreement to care for your child is made with you.

Non-Covered Services: Please be aware that some and perhaps all of the services you receive may not be covered or not considered reasonable or necessary by your insurer. We ask that you please pay for these services within 30 days of being notified of your financial responsibility.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Coverage Changes: If your insurance changes, please notify us before your next visit, so we can make the appropriate changes to help you receive your maximum benefits. We anticipate that your insurance company will pay for the services that you receive in 45 days, if that doesn’t happen; your assistance in getting your claim paid is greatly appreciated. We want to avoid holding your responsible when in fact it’s your insurances’ responsibility to pay.

Nonpayment: If you account is over 90-120 days past due you will receive a letter stating that you have 20 days to pay your account in full. We take great pride in working *WITH our PATIENTS* in resolution of any payment issues. Please make an attempt to negotiate a payment arrangement that is satisfactory with the practice as well as your budget. If that communication does not happen, there will be no choice but to defer your account to a collection agency and you maybe subsequently discharged from the practice.

No-Show: If you schedule an appointment but are unable to keep and do not call to cancel, after two missed appointments you will be charged the fee of a limited office visit.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for your understanding of our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Patient Name (please print)

Signature of patient or responsible party