ALTITUDE PULMONARY & CRITICAL CARE ASSOCIATES

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Financial & Payment Policy

Thank you for choosing us as your health provider. We believe that good care for you and your family starts with good communication, and we have created this policy to help our patients understand their financial responsibilities. If at any time you have questions, please ask us. Please sign below after reading this policy. A copy will be provided to you upon request.

1. **Payment for service.** Payment is due at the time of service unless other arrangements have been made. We gladly accept most major credit cards including Amex, Visa, MasterCard, Discover, and personal checks or cash. Ask us about other financial arrangements available.
2. **Insurance Coverage.** We participate in most major insurance plans. If you are not insured by a plan that we are a provider for, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
   a. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. To confirm your insurance eligibility, please provide us with a copy of your driver's license and current valid insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
   b. **Coverage changes.** If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in **45 days**, the balance may automatically be billed to you.
3. **Out-of-Pocket Responsibility**: In some cases, our fees may be adjusted based on whether we participate in or accept insurance or government program payments, allowances, or limitations. But, if we present a charge to you, it means that we have taken any such adjustment into account and that you must still pay the amount remaining. If you are reimbursed directly by a program for the cost of your care, you must still pay our charges promptly, whether or not you have received that reimbursement. If you do not agree with patient responsibility amounts or reimbursement amounts set by your insurance or government program, this is a matter between you and that program. We are happy to provide you with factual information about your care and billing to help you discuss this with them, but we still require you to promptly pay the entire charge we present to you, even if your issue with the program is not resolved.
   a. **Copayments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
   b. **Non-covered services.** Please be aware that some--and perhaps all--of the services you receive may be non-covered or not considered reasonable or necessary by your insurance plan. You must pay for these services in full at the time of the visit.
4. **Claims submission.** As a courtesy to you, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.
5. **Nonpayment.** If your account is over **60 days** past due, you will receive a letter from us or our agents stating that you have to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have **30 days** to find alternative medical care. During that **30-day period**, your doctor will only be able to treat you on an emergency basis.
6. **Missed appointments.** Our policy is to charge a fee equal to **$50 for missed appointments** NOT canceled or rescheduled prior to 48 hours of your scheduled appointment. This will allow more availability for patients who desire to be seen. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
7. **Returned Checks.** All returned checks will be subject to an external collection service and a **collection fee of $25**. In addition, to cover the cost for returned checks, you will be charged an **administrative fee of $25** (which includes the bank penalty charges incurred) and the cost of certified mailing in the addition to the amount of your returned check amount.

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

I have read the above. I fully understand and accept the terms and conditions set forth.