Island Family Medicine, PLLC
Statement of Financial Responsibility

This practice is committed to providing the highest quality of care to our patients. In order to do this, we must maintain excellence in the clinic, as well as in our business office and other areas of the practice. Medical costs continue to rise and reimbursements continue to decline so it is our policy to effectively manage our patients' accounts to minimize cost increases which directly impacts you, the patient.

The purpose of the policy is to provide guidelines and specific instructions related to gathering and maintaining accurate patient information, billing for services rendered, and efficient collection activity. Please note, these instructions may be modified periodically to ensure we maintain efficient and appropriate protocols related to the business office function.

*****PLEASE NOTE THIS OFFICE BILLS AS PRIMARY CARE PROVIDERS NOT AN URGENT CARE FACILITY***** If your insurance only reimburses for services performed in an urgent care setting, you should contact them prior to seeking care in our office.

Self Pay Financial Policy
Island Family Medicine, PLLC (IFM) requires a fee of $175.00 be paid before being seen by the provider for new patients or $125.00 for established patients. If additional services not included in upfront cost are necessary additional charges will be discussed with patient before treatment is given. Patient will be responsible for these charges at time of service.
Treatment will not be administered to any patient whose balance exceeds $100.00, except for medical emergencies.
Our fees are set based upon AMA's determination of reasonable and customary charges for this area.

Commercial Insurance Financial Policy
IFM accepts the following: Medicare, Established Medicaid, BCBS, United Healthcare, Cigna, HUMANA, Aetna, Medcost, TriCare, Three Rivers Provider Network (TRPN), Primary Physicians Care (PPC), Wellpath, First Health, PHCS
NO OTHER INSURANCES WILL BE ACCEPTED

We need for you to understand that your insurance coverage is just that, YOUR coverage. It does not release you from any financial obligation for the services we render to you.
If your insurance is not listed above, IFM will happily treat you as a self-pay patient and the above terms will apply.
If you are a new patient, or your insurance ever changes, you must furnish us with a copy of your insurance card prior to treatment. This card should be given to us within a reasonable time so that we can verify coverage and obtain your benefits before being treated.
Some insurance policies require a referral from your primary care physician. It is your responsibility to make sure we have that referral prior to your first date of treatment. Otherwise, you will be held responsible for the balance.
If we are unable to verify your coverage, you will be held responsible for any balance. Upon receipt of verification of coverage, we will then file your insurance.
We require our patients to pay 100% of their initial charges and all charges incurred up to the amount necessary to cover their insurance policies deductible.
We require that you pay your co-insurance balance or co-pay at the time of service. A patient's outstanding balance shall not exceed $100.00 or your professional care may be terminated.
If for any reason your insurance company has not covered your treatment within 120 days, you will be classified as a self-pay patient for outstanding dates of service.
Once ALL insurance payments have been received and it is deemed you have made an overpayment, we will refund any overpayments to you promptly.

Medicare Financial Policy
Medicare requires that you pay $198.00 deductible per calendar year. We must collect any outstanding deductible due on the day that services are rendered. After the deductible is satisfied, Medicare will pay 80% of allowed charges. If you do not have secondary coverage as a supplement, you will be responsible for 20% of those charges on the day the services are rendered.

Policy for Workman's Compensation
We do not participate in reimbursement from Workman's Compensation. However, we will still treat you as a patient, but payment will be expected at the time of service and will be the patient's responsibility.

Policy on Automobile or Personal Injury Cases
It is important for you to understand that you are responsible for payments of services rendered from our clinic for injuries suffered in an automobile accident or personal injury.

Medicaid Financial Policy
Our Medicaid patient enrollment is closed at this time, unless you have been assigned to this practice or one of our physician's through Carolina Access.

Missed Appointments/No Shows
Our policy is to charge for missed appointments not cancelled within 24 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments. Missed appointment fee is $25.00.

Miscellaneous Information
For your convenience we accept cash, debit cards, check, Visa, Master Card and Discover.
We require that any amount due be paid at the time of check-in, in order to expedite the checkout process.
The fee for a returned check is $25.00. If you submit a check with insufficient funds, your professional treatment may be suspended until your balance is paid. Checks will no longer be accepted from a patient who has a returned check.
No out of state checks will be accepted. Social Security # for the guarantor will be required before being seen by our physicians.
Any patient account balance over 120 days past due, will be turned over to an outside collection agency.

Signature Required

I, _____, have read the above policies and procedures, regarding my financial responsibility to ISLAND FAMILY MEDICINE, PLLC for providing medical services to the above named patient or myself. I authorized my insurer to pay any benefits directly to ISLAND FAMILY MEDICINE, PLLC. I agree to pay ISLAND FAMILY MEDICINE, PLLC in full the entire amount of all bills incurred by me or the above named patient. If I chose not to pay my outstanding debts I am aware that I am liable for all collection and/or attorney fees.

Patient Name: _____ Patient Signature _____ Date _____

Legal Guardian/Parent _____ Relationship to Patient: _____