## Bull Run Family Practice Financial / Payment Policy

We are doing everything possible to hold down the cost of medical care and we agree to provide quality medical care at a fair and reasonable price. You can help a great deal by eliminating the need for us to bill you and by understanding the benefits of your insurance. The following is a summary of our payment policy.

**PAYMENT IS EXPECTED AT THE TIME OF SERVICE:** Payment is required at the time services are rendered, unless other arrangements have been made in advance. This includes applicable coinsurance, co-payments and outstanding account balances. Bull Run Family Practice accepts cash, personal checks,Visa/MC and Discover. When you provide a check as payment you authorize us to use information from your check to process a one-time Electronic Funds Transfer -EFT or draft drawn from your account, or to process the payment as a check transaction. You also authorize us to process credit adjustments, if applicable. If your payment is returned unpaid, you authorize us to collect your payment and the Return Fee of $50.00 by EFT(s) or draft(s) from your account. Patients with an outstanding balance of $100.00 or 60 days overdue; must make arrangements for payment prior to scheduling appointments.

Our Billing Representatives are available to discuss payment arrangements with you, Monday – Friday between 8:00AM and 4:00PM, at 703-367-5720. INSURANCE: Your insurance policy is a contract between you and your insurance carrier. Bull Run Family Practice is not a party to that contract. We MUST emphasize, that as your healthcare provider, our relationship is with YOU and not your insurance company. We bill participating insurance companies as a courtesy to you. Nevertheless, YOU are responsible for payment regardless of your insurance company's decision to deny coverage or to reimburse less than the allowable charge. You are expected to pay your deductible, co-payment and outstanding balances at the time of service. This includes co-payments for siblings who are seen as "tag-a-longs" without a previously scheduled appointment. Your contract with your insurance company determines the amount of your co-pay and other patient responsibilities. Oftentimes, co-payment amounts are not clearly indicated on your insurance card. It is your responsibility to know whether or not you have a co-pay and to pay it at the time of service. If our check-out staff does not "ask" you your co-pay amount or if your co-pay is not clearly indicated on your insurance card, this is not considered a waiver of your contractual requirement with your insurance company to pay this fee nor is it to be construed as our waiver of acceptance of your co-payment at the time of service.

Please understand the benefits your insurance provides for office visits. It is your responsibility to know what services are covered. If you are unsure, check with your employer or call your insurer. As board certified physicians, we follow guidelines established by the American Academy of Family Physicians for rendering appropriate, quality medical care regardless of the provisions for coverage you have with your insurance company. It is your responsibility to be aware of your insurer's provisions for payment of office visits, laboratory and x-ray procedures, hospitalizations, immunizations, well-child exams and routine annual exams including school, camp or sports physicals.

Patients who arrive to be seen in our office with invalid/terminated insurance, lack of proof of continuing coverage (new insurance pending), or the wrong doctor's name on the card will be seen if

payment for the visit is received at the time of service. Oftentimes, claims are denied because your insurance company has requested additional details from YOU. Examples are 'Coordination of Benefits" (COB) questionnaires and written requests for "accident" information. Your insurance company will not pay until you fulfill their request. Once again, the provisions of your insurance are between you and your insurer. In these cases, you will be billed for outstanding charges until the insurer receives the information from you, and you ask the insurer to reprocess the claim and we are ultimately paid for our services.

If you need assistance or have questions, please contact the Office and ask to speak with a Billing Representative between 8:00AM and 4:00PM, Monday through Friday at 703-367-5720. Our physicians and nurse practitioners focus their time and attention on patient care and will therefore defer all billing questions or concerns to our billing office. We welcome the opportunity to discuss any aspect of our financial/ payment polices with you.

**REFUNDS:** Overpayments, credits, and unapplied credits on a patient account will be refunded upon written request to Bull Run Family Practice from the responsible party within 30 days.

**MANAGED CARE:** If you are enrolled in a managed care insurance plan, (i.e. HMO, PPO) you must verify that one of our doctor's names is on your insurance card. If your insurance card does not list us as your Primary Care Provided (PCP) and denies payment, we will bill you for all services. Oftentimes, there is a window of opportunity for you to change your PCP- please check with your insurer for the correct timing of this change. If your insurance requires referrals to see a specialist you must request the referral prior to your appointment. NO retroactive referrals will be given.

**MISSED APPOINTMENTS /LATE CANCELLATONS:** Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We will charge $50.00 for missed or late-canceled appointments. Should you miss more than two appointments and fail to cancel in advance, you will be charged $100.00 office visit fee. The next time you miss an appointment you may be discharged from the practice.

**PATIENT BALANCES/ACCOUNTS OUTSOURCED TO COLLECTIONS:** Just as we receive an "Explanation of Benefits" (EOB) with payment from your insurance company, you too should receive a copy from the insurer that will detail any outstanding balances you owe us. All bills for patient balances are mailed to the address of record. There is no provision for us to "magically" ascertain that we have the correct address. Therefore it is imperative that you update us with any and all changes to your account whether it is a change of address, phone number, insurance etc. On the rare occasion that our computer does not generate a statement for you of monies owed or your bill has gone to an old address, we will assume that you have been notified by the EOB sent to you from your insurer. Any and all outstanding balances over 90 days with no payment activity, no attempt to pay or dialogue with our billing office may be turned over to our collection agency. Please do not ignore these statements; please contact us to help you meet your obligations. Any patient who has transferred out or was discharged

from the practice due to a billing problem will be required to pay the previous balance prior to being seen again.

**ADDITIONAL CHARGES:** Any visits that are unscheduled (walk-ins) are subject to an “emergency services” fee.

BRFP uses Medical Records Online (MRO) to copy all of our medical records. You must complete a “BRFP Authorization for Release of Medical Information” form prior to your records being copied. MRO charges a fee for this service, which conforms to State code. BRFP does not benefit financially from this service. All questions regarding the copying of your records should be directed to a MRO representative at 888-252-4146. MRO will contact each requestor and provide a means of communication to you and a means for you to track the status of your request.

As a patient of Bull Run Family Practice I consent to the Financial/Payment Policy. I agree to assign insurance benefits to BRFP whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections. By signing below, you acknowledge and agree to the above terms.

_______________________________________________________ Print Name Date _________________

________________________________________________________________ Parent/Guardian Signature