Pulmonary & Critical Care Medicine Associates
Expertise, Compassion, Results

Address: 50 N 12th Street, Lemoyne, PA 17043
Phone: 717-234-2561

FINANCIAL POLICY

Thank you for choosing our practice as your health care provider. The following is a statement of our financial policy, which we request that you read and sign prior to any treatment.

INSURANCE

Your health insurance policy is a contract between you and your health insurance company. We will submit the medical services to your insurance carrier if you have given us all of the required information. We must have correct policy, group, ID, or claim numbers, etc., along with a correct billing address or a completed claim form. Please be aware that some and perhaps all of the services provided may be a "non-covered" service according to your policy. You are still responsible for payment of these services.

UCR (Usual and Customary Rates)

Our practice is committed to providing quality care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company being unwilling to pay for the quality of care you choose.

BILLING

If you have a financial problem, please ask to discuss a payment plan with our billing department. A billing statement covering medical services received will be mailed to you on a monthly basis. If an extended payment plan has been offered to you, we require regular monthly payments or the plan is void. After then, the account may be turned over to our collection agency. You then will be responsible for any collection costs. We accept cash, checks, Visa, or MasterCard for payment. In the event a personal check is returned unpaid from your financial institution for any reason, your account will be charged a $20.00 returned check fee. If you are on an extended or monthly payment plan, you are required to pay the balance within 12 months.

DISABILITY FORM PREPARATION

If you have disability forms that need to be prepared by our office, we will do these at a nominal, prepaid charge per form. We try to do them as quickly as possible but they may take up to 2 weeks for completion.

COLLECTION BALANCES

If you had a previous collections balance or are presently in collections, the physician may use his discretion as to seeing you again. It may be required that you pay your previous balance prior to being seen. If seen by the doctor, we must verify current insurance coverage. You will be responsible for payment of the office visits, co-pay, etc., on the day of or prior to your visit.

CANCELLATION POLICY

Please help us serve you better by keeping your scheduled appointments. Notify us at least 48 hours in advance if you are unable to keep your scheduled appointment. **Failure to show and/or notify us within 24 hours may jeopardize your next office visit and you will be charged a $50.00 fee for your Office Visit. Failure to show and or/ notify us within 2 business days of your next Pulmonary Function tests or Sleep Study, you will be charged $75.00 for a Pulmonary Function Test, $50 for a Home Sleep Test, and $150 for Sleep Studies.** Please be advised that insurance companies, as well as Medicare, will not cover these no-show fees, so you will be responsible for payment.

I have read the above financial policy. I understand and agree to this financial policy. I agree to the terms of payment due.

Signature of Patient or Responsible Party _____ Date _____

If you have questions about of financial policy, please contact our billing office at (717) 234-2561