

ERIE PHYSICIANS NETWORK, PC
PAYMENT POLICY January 4th, 2010

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we thought it would be in your best interest to develop a payment policy. Please read it, ask any questions you may have, and sign in the space provided. A copy will be provided to you upon your request.

Insurance. We participate with most major insurance companies, including Medicare, Highmark & Health America. If you are not insured by a company that we participate with, we will bill your insurance company for you, but the balance will always remain your responsibility until payment is received. If you are insured by a company that we are participating with but do not have your current insurance card, the balance will remain yours until we receive the updated insurance card and can verify coverage.

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

Cash Payment Only. Payment must be made prior to the time of service unless other arrangements are made in advance of the service.

Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be "non-covered" or considered "not reasonable or necessary" by Medicare or other insurers. If the service is non-covered you will be required to pay for these services in full. If the service is considered not medically necessary by Medicare, you will be asked to sign an Advanced Beneficiary Notification and after submission to Medicare you will be required to pay for these services in full.

Proof of Insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license or a valid photo ID and a current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claim submission. 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.

Coverage changes. If your insurance changes, please notify us before your next visit so that 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 will automatically be billed to you.

Non-payment. If your account is over 60 days past due, you will receive a letter stating that you have 20 days 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, our physicians will be able to treat you only on an emergency basis.

Missed appointments. Our policy is to charge for missed appointments not cancelled at least 24 hours in advance. These charges will be your responsibility and billed directly to you. Once a patient has had 3 or more missed appointments, you may be discharged from the practice as well. Please help us to serve you better by keeping your regularly scheduled appointment or canceling at least 24 hours in advance.

Financial Responsibility Form. You will be asked to read and sign our Financial Responsibility form. This provides you with more information and gives us permission to bill your insurance company for any services incurred during your visit. It also validates your knowledge of our financial policy and your responsibility for any balances on your account. This form is good for one year and you will be asked to sign it at your first visit of the new year.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of 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 and understand the payment policy as stated above and agree to abide by its guidelines.

Signature of patient or responsible party

Date

Due to new banking laws, EPN will be using a function that will allow us to convert your patient payment from checks to electronic payments. If you pay by check, please read and sign the following disclosure.

I authorize my check to be converted to an electronic payment, and authorize the merchant, or its collection agent, to electronically charge my account as NSF Fee, not to exceed maximum set by law, if my check is returned for non-sufficient funds (NSF), CANCELLED CHECK.

Signature of patient or responsible party

Date