The office of
Dr. Brian Shiple

FINANCIAL POLICY

WE KNOW THAT CHOOSING A PHYSICIAN IS A VERY IMPORTANT DECISION AND WE THANK YOU FOR CHOOSING OUR OFFICE. PLEASE TAKE A MINUTE TO CAREFULLY READ THIS OVERVIEW OF SOME OF OUR FINANCIAL POLICIES.

INFORMATION REGARDING YOUR INSURANCE COVERAGE

You must be informed of and understand the details of your health insurance coverage and fulfill any associated requirements (e.g., pre-certification, obtaining referrals, providing information regarding preexisting conditions, etc.). It is also your responsibility to provide our office with all required information regarding your health insurance coverage. It is important that you promptly notify us if there are any changes to your insurance information. If any complications arise during the billing process, you have an obligation to promptly provide assistance and information to our billing office (internal and/or external) and if your failure to timely provide this information or assistance results in a denial of coverage, you may (in certain circumstances) become personally responsible for paying for the services.

UNINSURED PATIENTS

If you do not have current health insurance coverage, the entire payment for any services performed shall be paid at the time of service. If this creates a hardship, please speak with the billing staff to make payment other payment arrangements.

NON-PARTICIPATING PROVIDER OR NON COVERED BENEFITS

If we do not participate with your health insurance carrier, or if the services provided are not covered under your particular health insurance plan, then you are responsible for paying for all services at the time of service. If you would like us to do so, we can (upon your request and full payment) provide a statement for your records and/or reimbursement purposes. (Please Note: In certain rare circumstances and in our sole discretion- we may directly bill your insurance carrier as an out-of-network provider in lieu of accepting payment directly from you and if we do so, you agree to assign your payment rights [IN WRITING] to our office and forward us any checks you receive relative to the services we have provided to you.)

PARTICIPATING PROVIDER AND COVERED BENEFITS

If we participate with your health insurance carrier and the services sought are covered services under your particular health insurance plan, then we will directly bill your health insurance carrier. Under your plan, you may be responsible for paying certain amounts (e.g., co-payments, deductibles and fees for non-covered services), which are due at the time of service.

TYPES OF PAYMENT; DISHONORED CHECKS

Our office accepts cash, personal checks and credit cards(Visa and Mastercard). If your check is dishonored (e.g., refused for insufficient funds), you will be required to pay an additional fee of Twenty-Five Dollars ($25), which shall be due and owing immediately.

COLLECTION OF OUTSTANDING BALANCES

All outstanding balances shall be due within 30 days. Unless we have agreed to other payment arrangements in writing, it is important that you pay all past due balances, in their entirety, prior to or at the time of your visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency or attorneys' office. If your account is referred to a collection agency, you will be responsible for paying a collection charge equal to 35% of your outstanding balance, which is in addition to your outstanding balance and any applicable interest. If your account is referred to an outside attorney, you will be responsible for paying all reasonable attorneys' fees and court costs, which are in addition to your outstanding balance and any applicable interest.

MISSED APPOINTMENTS

It is important that you appear for all scheduled appointments. By way of courtesy, we usually (but need not) call to confirm your appointment a day or two before the scheduled appointment. If speaking to you is not possible for any reason, we attempt to leave a reminder message with a family member or on an answering machine/voicemail. Your failure to cancel an appointment in a timely manner (i.e., ill least 24 hours prior ill the visit) deprives other patients of an opportunity to visit our office. *You* will be responsible for a paying a missed appointment fee of Sixty Five Dollars ($65) for a 30 minute appointment and One Hundred Thirty Dollars ($130) for a 60 minute procedure if you fail to appear for a scheduled visit and have not provided at least 24 hours advanced notice of cancellation. This policy is aimed at minimizing the waiting time and ensuring availability of prompt medical care. We recognize the fact that there may be circumstances which may not permit you to give us 24 hours prior notice but such circumstances are exceptional and extremely infrequent and shall be considered on a case to case basis.

RELEASE OF MEDICAL RECORDS

Medical records created by our office shall only be released pursuant to your express written authorization in accordance with HIPAA or other controlling laws (or under other circumstances as required by law). We charge a photocopying fee of One Dollar ($1) per page, with a minimum fee of Ten Dollars ($10) and have up to thirty (30) days to produce your records. If permitted under the law, we may charge higher fees to attorneys who request your records.

MISCELLANEOUS FEES

Certain services (e.g., completing forms, producing narrative reports, personal letters, etc.) may entail additional fees. Prior to requesting any such services, you should request a copy of our miscellaneous services fee schedule.

By signing below, patient or responsible party acknowledges that he or she has read and understood the foregoing Financial Policy and agrees to be bound by the terms and conditions set forth therein.

Signature of Patient or Responsible Party _____

Print Name of Patient and Responsible Party (if any) _____

Date _____