



Main Line HealthCare
Physician Network

Patient Name (Please Print): _____ **Date of Birth:** _____

PATIENT FINANCIAL POLICY - FORM – ZFPF

Main Line HealthCare physicians and staff are committed to providing you with the best possible care. We will be happy to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE unless previous arrangements have been made. In the case of a minor, the patient's accompanying adult, parent, or guardian is responsible for payment at the time of service. This includes all insurance co-pays. **WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD.**

WE PARTICIPATE WITH THE FOLLOWING INSURANCE CARRIERS:

Aetna, Blue Cross/Blue Shield of Pa (including Premier Blue), ChoiceCare Network (aka EHI/Humana, Cigna HealthCare: Great West Life, One Health, Clear Care Network (aka Humana PPO), Coventry Health Care: Coventry Health Plan of Delaware, First Health Network, Community Care Network (CCN), Health America Health Assurance, Health Payors Organization (Interplan Health Group – IHG), Devon Health Services, Galaxy Health Network, Independence Blue Cross (KHPE, Personal Choice & Amerihealth), InterGroup, Medicare/RR Medicare, Multi-Plan/Private HealthCare Systems (PHCS), PPO Next (A Viant Network), MasterCare, Health Star, Preferred Health Network (PHN), Beech Street, Preferred Care, Inc., Tricare/Champus, - Authorized, United HealthCare: Mamsi, Oxford, Evercare, (Medicare population – Nursing Homes)

If you are covered by any of these carriers, it is necessary for you to provide our office staff with the required information that enables us to bill your carrier. In some circumstances, even participating insurance plans may leave a balance that you must pay. It is not our responsibility to know what limitations, exclusions, deductibles or co-pays each group insurance plan might leave to a patient's responsibility. **Your doctor may participate** with other insurance plans not listed above. Please check with the practice office staff to see if your insurance plan will be accepted.

MAIN LINE HEALTHCARE DOES NOT ACCEPT DISCOUNT CARDS.

NON-PARTICIPATING INSURANCE PLANS

Office Charges: Insurance will *not* be accepted for office charges for non-participating insurance plans; however, a receipt will be provided that includes all of the required information for you to submit to receive reimbursement from your insurance company.

Inpatient, Nursing Facility and Procedure Charges: If an inpatient service or office diagnostic /surgical procedure is performed, we will file an insurance claim as a courtesy to our patients. You must provide our office with specific insurance company information in order for this claim to be filed. If payment has not been received after 30 days, the balance will be transferred to your responsibility. We will not become involved with disputes between you and your insurance company regarding deductibles, co-insurance, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. As the insurance policy holder, you are responsible for timely payment of your account.

DELINQUENT ACCOUNTS

An account is considered past due 30 days following billing unless other arrangements have been made. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to a collection agency.

MISSED APPOINTMENTS

We would appreciate your help and the courtesy of a call if **you are unable to keep your scheduled appointment. Please notify our office at least twenty-four (24) hours prior** to the appointment time. We reserve the right to charge a missed appointment fee for each appointment that is not canceled in a timely manner.

RETURN CHECK FEE

There will be a transaction fee of \$15 for any check that is returned for insufficient funds.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH, READ, AND UNDERSTAND THE PATIENT FINANCIAL POLICY STATED ABOVE AND AGREE TO BE SUBJECT TO SAME.

Patient Signature: _____ **Date:** _____