Southeastern Lung Care and The Sleep Disorders Centers

Financial Policy

Full payment is due ***at the time of service***, including all deductibles, coinsurance, copays, and past due balances. If your insurance carrier considers any service a non-covered service, or if you are paid directly by your insurance carrier, payment will be expected in full at the time of service. All payment arrangements must be ***prior*** approved by the Practice CEO and/or Practice Manager. Payment arrangements will only cover the specific charges and dates of service agreed upon. They will ***not*** cover additional charges or dates of service. We accept cash, check, money orders, VISA, MasterCard, and American Express. Our practice is committed to providing the best treatment for our patients and we charge what is usual, customary, and reasonable for the geographic areas we cover. All checks submitted to our office will be processed through ***Telecheck*** in order to verify availability of funds. Should your check be returned by the bank due to insufficient funds, you will be assessed a returned check fee of $30.00.

Our office will file your claims to your insurance carrier(s) as a courtesy to you. Your insurance coverage is a contract between you and your insurance carrier. Your entire account balance, including charges filed to your insurance company, is ***your responsibility.*** You are responsible for follow-up communication with your insurance company should there be any problems in processing a claim. It is your responsibility to know your plan benefits. You are financially responsible for all copays, coinsurance, and deductibles required by your insurance carrier. Any unpaid balances will be subject to collection procedures. Please be aware that some, or perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under any federal programs, commercial insurance plans or self-insured plans. ***You will be held responsible for these services.***

There will be a $20 fee charged for all missed appointments and/or no shows. A missed appointment is considered as such if you fail to contact our office and give a 24-hour notice of canceling an appointment, or you fail to show for your scheduled appointment. ***These missed appointment fees will not be covered by your insurance carrier and will be billed directly to you.*** You will not be charged a missed appointment fee if our office cancels or reschedules your appointment.

For sleep study patients, if you must reschedule, we require a 24-hour notice. Tests scheduled for Saturday or Sunday must be cancelled by 5:00 PM on Friday. If you cancel or miss your appointment without the required 24 hour notice, we will assess a $75.00 cancellation/no show fee. ***These missed appointment fees will not be covered by your insurance carrier and will be billed directly to you.*** You will not be charged a missed appointment fee if our office cancels or reschedules your appointment.

You are asked to confirm your demographic and insurance information at every visit. Should you provide us with incorrect information, our office will charge a $25.00 misinformation fee for each visit that incorrect information is provided. ***This fee will not be covered by your insurance carrier and will be billed directly to you.***

If you are receiving CPAP/Bi-Level equipment, your insurance company may require that you complete a compliance/rental period. Once you have completed the compliance/rental period, your insurance company will be billed for the purchase of the equipment. Once we have billed your insurance company for the purchase of the equipment, you cannot return the machine. If you wish to return the machine during your compliance/rental period, you will still be billed for all disposable items used during your compliance period to include the humidifier, mask, headgear, tubing, chin strap, and filter(s).

If your account must be turned over to an outside collection agency, you will be responsible for your entire account balance ***plus*** a collection agency fee equal to 33% of your account balance.

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Signature of Patient or Responsible Party Date

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Print Patient Name SELC Patient #

Updated 5.7.12