First in Primary Care **Broadway** MEDICAL CLINIC

FINANCIAL POLICY SUMMARY

_____ **Payment Responsibility** – Patient and/or Guarantor assume responsibility for all charges resulting from treatment provided by Broadway Medical Clinic, L.L.P. We bill most insurance carriers in expectation of prompt payment. Responsibility for unpaid balances is that of the Patient and/or Guarantor. Payment for service is due within 15 days of receipt of statement, unless financial arrangements are made in advance.

It is the responsibility of the Patient and/or Guarantor to understand the terms, deductibles, and conditions of their insurance plan. Insurance providers do not always cover preventive or well care visits. Contact your carrier's Member Services Department for clarification. When insurance information is unavailable or valid insurance information is not provided prior to or at time of service, the Patient and/or Guarantor will be held responsible for charges incurred. A deposit will be collected at time of service of $100.00. The clinic has a self-pay fee schedule. No discounts are provided on laboratory, imaging or medication services.

______**Divorced Parents –** Both parents are held equally financially responsible for services provided to minor children.

_____ **Uninsured Patients** – Patient and/or Guarantor are required to pay a minimum of $100 towards estimated charges related to their appointment at time of service. Individuals excluded from this are contracted Health Plan enrollees with current eligibility, Medicaid enrollees, Medicare subscribers carrying traditional Medicare or a Medicare Managed Plan with which we participate and Workers' Compensation claimants.

_____ **Appointment Requirements** – In compliance with Federal Fraud and Abuse guidelines, we ask that Patient and/or Guarantor present at each visit*; Photo ID, the Patient's current insurance identification card(s),*and be prepared to pay all applicable co-pay. We also ask to be advised of any change in insurance coverage and communicate change in name, address, telephone numbers, and employer. The clinic is not responsible for claims billed outside the insurance guidelines if correct insurance information is not provided at time of service.

_____ **Co-payment** – Co-payments are due at the time of each visit. Failure to pay the co-payment at time of visit may result in a billing fee. Your insurance company may apply an additional copayment at time of claim processing for such services as imaging, laboratory or procedures based on your plan design.

_____ **Health Insurance** – Broadway Medical Clinic, L.L.P. will bill most employer sponsored insurance carriers as a courtesy to our patients. Secondary insurance will be billed as a courtesy when information is presented at time of service. Newborns must be added to insurance within 30 days of birth.

_____ **Medicaid/Oregon Health Plan or other State subsidized plans** – Enrollees are required to bring their current Medicaid eligibility card Please be prepared to pay any applicable copayment at time of service.

_____ **Medicare** – Broadway Medical Clinic, L.L.P. physicians participate in traditional Medicare and certain Medicare Advantage plans. **Medicare Managed Plans accepted are: MODA, BCBS, Providence, HealthNet, Care Oregon, Family Care**. A patient not on one of these plans can be seen at Broadway Medical Clinic but will be considered self-pay and will sign an ABN.

_____ **Motor Vehicle Accident** – Patient and/or Guarantor are required to inform Broadway Medical Clinic, L.L.P. at time of scheduling if services are related to a Motor Vehicle Accident. All charges related to a Motor Vehicle Accident (MVA) are the responsibility of the patient. However, we will bill the patient's automobile carrier as a courtesy but we do not hold for 3rd party liability.

_____ **Workers' Compensation Claims** – Patient and/or Guarantor are required to inform Broadway Medical Clinic, L.L.P. prior to each visit when medical services are related to a Workers' Compensation claim and to file an accident report with their employer and present proof of claim for medical services. An 827 is to be completed at the 1st point of care following the injury. Should the claim be denied, Patient and/or Guarantor are responsible for the appeal process.

_____ **Missed Appointment Fee**: A fee of $50-75.00 may be charged for each appointment missed without 24-hour notice.

_____ **Rebilling Fees**: Unpaid balances exceeding 8 weeks and copayments not paid at time of service will be subject to a $5.00 per month rebilling fee.

_____ **Returned Check Fee / Declined Credit Cards**: A $35 fee will be charged if your check is returned from your bank unpaid or if your credit card is denied.

As Patient and/or Guarantor, I agree to the terms and conditions of Broadway Medical Clinic, L.L.P. financial policies.

Signature: ____ Date: __________________

You may contact our Financial Counseling Department at (503) 331-7665. 20150520