233 Ayer Road, Suite 10 • Harvard, MA 01451
(978) 772-0698 • (978) 772-0024 (FAX)
info@HarvardFamilyMedicine.com
HarvardFamilyMedicine.com

Payment Policy

Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1) **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2) **Co-payments and Deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us by paying your co-payment at each visit.

3) **Non-covered Services:** Please be aware that some — and perhaps all — of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4) **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 and current valid insurance 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.

5) **Claims 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.

6) **Coverage Changes:** If your insurance has changed, please notify us before your next visit so 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.

7) **Non-payment/Collections:** If your account is over 90 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 a fee of 25% will be applied to cover the cost of collections, this fee may be 50% if it requires litigation. You and your immediate family members may also be discharged from this practice for non-payment. If this occurs you will be notified by mail that you have 30 days to find another physician. During that 30 day period, our physicians will only be able to treat you on an emergency basis.

8) **Missed Appointments:** Our policy is to charge for missed appointments not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

9) **Automatic Dialing System (ADS):** Our office or authorized agents may use an automatic dialing system to contact you regarding appointments and/or balances. By signing this agreement you give consent to allow calls from an ADS to all phone numbers provided on your account.

Harvard Family Medicine is committed to providing the best treatment to our patients. Our prices are a representative of the 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 and agree to abide by its guidelines.

____ Signature of Patient or Responsible Party

______________________________ Date