Community Family Practice, PA

Billing Policy

Thank you for choosing us as your primary care provider! We are committed to providing you with quality and affordable health care. We understand that insurance and medical billing is complicated, so we've created this guide to help our patients understand standard billing policies.

1. **Insurance**
   We participate with most insurance plans, including Medicare and tailored Medicaid plans, however to ensure we are partnered with your specific plan, please contact your insurance provider directly. Over the years, we have found some insurance providers that we are partnered with have carved out restricted networks. Restricted networks may translate into premium savings for the patient; however, it means that even if we partner with that insurance plan, a provider has to be invited in to that specific network for their services to be covered. Any provider outside of the smaller, restricted network will be considered out-of-network. This is why we can't fully answer the question: "Do you take my insurance?".
   - A glossary of insurance terms can be found at the end of the Billing Policy
2. **Proof of Insurance**
   Please bring your insurance cards with you to every appointment. Failure to provide an insurance card may result in your claims being denied and incorrect or out-of-date insurance information impacts referrals, labs, vaccines, and billing. To avoid these issues, we will routinely ask to see your insurance card. We will need information from both the front and back of the card and will ask to make a copy for our records.
3. **Claims submission**
   As a courtesy, we will submit your claims to the insurance that you provide to us. Each insurance company has a set "Timely Filing Deadline". This means that we have a certain amount of time to file your claim. If your insurance is updated outside of that timeframe, the insurance company will deny the claim and the patient will be responsible for the bill. Claims not paid by insurance within 45 days are automatically billed to the patient.
4. **Payment**
   Co-pays and prior balances are expected at time-of-service. CFP utilizes Inbox Health for payment processing. Inbox Health will use 3 methods of contacting patients regarding their bills: text, email, and paper statements. **After 3 billing cycles, unpaid balances are**

subject to referral to a collection agency and discharge from the practice. (One billing cycle is 30 days, which includes multiple outreach attempts to collect on an outstanding balance.) If this is to happen, patients will be notified by mail that they have 30 days to find another primary care provider. During that 30-day period, our providers will only be able to offer urgent care services.

5. **Payment Plans**
   We offer interest-free payment arrangements that can be set up using the text or email link on your electronic invoices, or the QR code on your paper statement.
6. **Non-covered services**
   Please be aware that some of the services that you receive may be non-covered or not considered reasonable or necessary by your insurance provider. We will do our best to advise you if this is the case, however, every medical policy is different. If you're unsure if a service will be covered by your insurance carrier, we can give you a CPT code to share with them to determine coverage. Note that a "covered service" does not mean that insurance will cover it at 100%. Very often, a covered service will still be subject to your copay or deductible.
7. **Annual Exams**
   Annual visits (including well child checks, adult wellness exams and annual wellness visits) follow certain CPT coding guidelines. Annuals are set up to provide preventive services which include screenings (or referrals for screenings), screening labs (not for labs that monitor existing chronic conditions or acute symptoms), and vaccines. Acute or chronic problems that are addressed during an annual exam are coded separately. The benefit is that this will save the patient a separate visit to the office, however it will result in a charge for the patient (copay, co-insurance, or deductible). If you wish for your yearly wellness exam/physical to remain 100% covered by insurance, let your provider know and we can schedule a separate visit for you to discuss any other issues. *Most* insurance companies require annual exams to be scheduled 365+ days apart in order to be covered.
8. **Missed Appointments**
   Appointments missed for late-cancellation and "no-shows" are subject to a $45 missed appointment charge. Repeated missed appointments are subject to discharge from the practice. See the 'Appointment Policy' document at communityfamilyonline.com/forms for more detail on this policy.
9. **Glossary of Insurance Terms**
   <u>In-Network</u>: Providers have a contract with the insurance company. These contracts are agreements between the doctor's office and the insurance company in which the provider's office agrees to provide services at a pre-negotiated rate. This allows for potential cost-savings for the patient.

Out-of-Network: Providers don't have a contract with these insurance companies. This means the patient may be charged more or the insurance may cover a smaller percentage of the cost (or none at all). The patient may also be responsible for balance-billing, which is where the provider bills the patient for the difference between the charge and what the insurance paid.

Insurance Allowable: This is the amount an insurance will allow us to charge for a service. This varies by insurance company and contract. Charges above the allowable amount are adjusted off. After the adjustment, the patient may be billed the allowed amount as part of their co-pay, co-insurance, or deductible.

Premiums: The amount a patient pays the insurance company per month for coverage.

Co-pays: The dollar-amount determined by your insurance company as the patient-responsibility. This amount is applied to your deductible and out-of-pocket maximum.

Co-insurance: The amount determined by your insurance company as the patient-responsibility. This amount is often a percentage of the allowed charge and is often applied to lab/testing portion of your visit, in addition to the co-pay amount. This amount is applied to your deductible and out-of-pocket maximum.

Deductible: The amount a patient pays out-of-pocket before insurance starts to pay it's share.

Out-of-Pocket Maximum: The most a patient will pay for covered services throughout their policy year. Copays, Co-insurances, and Deductibles make up the Out-of-Pocket Maximum limit. Once this limit is reached, insurance will pay 100% of covered services.

Our practice is committed to providing the best treatment to our patients. Our prices are competitive with the customary charges for our area. If you have any questions or concerns about the accuracy of your bill, please contact our billing office at 828-254-2444, option 5 or send us a Portal message.