



2011 FINANCIAL POLICY

It is the policy of this office to help keep your health care costs as low as possible. In order to do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

- **ALWAYS** bring your current health insurance card to the office
- Please notify us at time of check in of any changes in insurance, address, phone #, etc.
- You will be responsible in paying your **COPAYMENT** at the time of service as well as any outstanding balances on your account; or if you do not have insurance, please come prepared to pay for your visit in full.
- You will receive a bill for any patient responsibility and/or an explanation of benefits from your carrier regarding your responsibility. If you do not, please contact the billing office at 513-351-9900 or 1-800-964-1587

Copayments: We are required by our insurance contracts to collect all copayments at the time of service. Copayments can be made by cash, check or credit card (Visa/Mastercard/American Express/Discover).

Monthly Statement: If you have a balance on your account, we will send you a monthly statement.

Payments: Unless other arrangements are approved by us, the balance on your statement is due and payable upon receipt of the statement and is past due if not paid within 30 days of statement date. We do offer interest free payment plans based on balance on your account.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect the debt. If we have to refer your account to an outside collection agency, you agree to pay all of the collection costs that are incurred.

Uninsured Patients: A patient who does not have insurance coverage through a federal, state or local government program or through private insurance is considered an uninsured patient. OHVC's policy is to assist our patients in meeting their financial obligation to pay for services rendered and to ensure that discounts are provided in a fair, consistent and objective manner. Financial Assistance programs are available for qualified patients who submit all necessary information

Insurance: It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier. If this is not known, it is suggested the cardholder verify coverage limitations prior to appointment date. You agree to pay any portion not covered by your insurance.

- **Referrals:** If your insurance requires a referral to see one our physicians, it is your responsibility to make sure the referral is in place prior to the appointment date. If referral is not in place, you agree to pay any portion not payable by your insurance due to no referral.
- **Multiple Insurance:** If you have multiple insurance plans, it is your responsibility that they coordinate correctly. Please make sure our office always has correct insurance and correct insurance order. Any Coordination of Benefit (COB) issues which is the process of determining the respective responsibilities of 2 or more health plans that have some financial responsibility for a medical claim will be directed to patient after 90 days if not resolved by patient. If patient does not resolve COB issue before insurance filing limit, the balance will be the patient responsibility.

Insurance Release: This is to certify that I have been informed prior to receiving treatment that my insurance may not be liable for service rendered if any of the following conditions apply:

- I may have a pre-existing condition or other diagnosis that may not be covered by my health plan
- Provider not participating in my health plan
- Unmet deductible under my health plan
- Services might not be covered under my health plan

Effective Dates: This policy is effective January 1, 2011.

Therefore, knowing this, I request that services be performed. I understand that if I fail to make payment when due and my account becomes delinquent, it can be turned over to a collection agency for collections.

In this agreement, the words "you", "your", and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to OHVC.

I have read this Financial Policy as outlined above and on the frontside of this page, and understand I am ultimately responsible for the charges incurred.

Please check here if you would like a copy for your records.

PATIENT PRINTED NAME: _____ Date of Birth _____

PATIENT SIGNATURE: _____

DATE OF SIGNATURE: _____