MICHELE M THOMPSON MD LLC
FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. It is important to us that the quality of our business services match the quality of our medical care. We are dedicated to providing the best care for you and believe that part of good health care is communicating our financial policies to our patients.

Insurance and Claims Submission. We participate in most major health plans. Dr. Thompson is *not* a contracted provider with Medicaid plans. We do not treat or bill for motor vehicle or occupational injury related visits. As a courtesy to our patients, we will submit claims for any services rendered to you to your primary and secondary insurance carriers. We do not bill tertiary insurance plans. Please present your insurance card(s) at the time of each visit. This ensures correct and timely billing on your behalf. If your insurance has not paid within 60 days, we reserve the right to make it your responsibility to follow up with them.

You, the patient, have a contract with your insurance carrier. It is *your* responsibility to know your benefits and if we are a participating provider with your plan. We do not guarantee that your insurance will cover the services rendered. Although we will submit claims for any services rendered to your insurance, complete payment is ultimately your responsibility.

Payments. Your insurance company requires us to collect co-payments at the time of service. Please come prepared to pay your copayment at each visit. Additionally, you may have co-insurance and/or deductible amounts required by your insurance.

Merchant Consents. In our office we require a merchant consent to cover your out-of-pocket expenses for each visit. Your out-of-pocket expense will be estimated based on your visit and insurance benefits. This consent authorizes us to charge your credit/debit or HSA card up to the agreed amount *after* your insurance processes the claim. Once we swipe the card, the number is encrypted immediately; we are not storing your credit card number. After your insurance processes the claim, we will charge your card without any further authorization or notification to you. If the amount you owe is more than the consented amount, we will charge the agreed upon amount and bill you for the remaining. If it is less, we only charge that amount.

Non-Covered Services. Medical services that are considered cosmetic, not covered by your insurance company, or deemed not medical necessary will be your responsibility. Payment in full is required at the time services are rendered.

Patients with No Medical Insurance. If you do not have medical insurance, payment for all services is expected at the time of your visit. We do offer discounted fees for patients without health insurance.

Non-Payment. Our policy is to collect all balances due from previous visits prior to your next visit. All patient balances that remain delinquent after 90 days with no response to our requests for payment, may be referred to a collection agency. Please be aware that if your account is turned over to a collection agency, you and/or your family members may be discharged from this practice.

Returned Checks. A $30 fee will be assessed to your account for each returned check. This fee and the original check amount must be paid in full with cash, credit card, or money order prior to your next appointment. After receiving two returned checks, we will no longer accept checks as a method of payment on your account.

Refunds. We do not issue patient refunds for amounts under $5 unless requested. We also do not send statements for balances due for under $5.

Missed Appointments. We may charge you for no show appointments and appointments canceled with less than 24 hour notice ($50 for general office visits, $100 for surgery or cosmetic appointments) . These charges are your responsibility and will be billed directly to you. A patient who fails to present themselves three times for scheduled appointments is considered a chronic no-show and may be dismissed from the practice.

Please feel free to contact us at (360) 450-6800 if you have any questions about your financial responsibilities.

I, ________________________________ (patient's name), acknowledge and agree to the terms of this financial policy. I understand that I am financially responsible for all charges weather or not paid by my insurance(s) and agree to comply with the terms set forth in this policy.

Signed ____ **Date** ________________

(Patient or Person financially responsible for the bill)