

# Lincoln Surgical Associates, APMC

## Patient Payment Policy

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Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

### How May I Pay?

We accept payment by cash, check, cashier's check or money order. We do not have in-house financing, but we can refer you to financial institution.

### Do I Need A Referral?

If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. It is the responsibility of the patient to obtain referrals. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled. Examples of insurances that require a referral are **Medicaid, Tricare, and Vantage.**

### What if My Child Needs to See the Physician?

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account.

### Which Plans Do You Contract With?

Please see attached list.

### What Is My Financial Responsibility for Services?

Your financial responsibility depends on a variety of factors, explained below.

## Office Visits and Office Services

If You Have...	You Are Responsible For...	Our Staff Will...
<b>Commercial Insurance</b> Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of the patient responsibility for all office visits, x-ray, injection, and other charges at the time of office visit.	Call your insurance company ahead of time to determine deductibles and coinsurance.  File an insurance claim as a courtesy to you.
<b>HMO &amp; PPO plans with which we have a contract</b>	<u>If the services you receive are covered by the plan:</u> All applicable copays and deductibles are required at the time of the office visit.  <u>If the services you receive are not covered by the plan:</u> Payment in full is required at the time of the visit.	Call your insurance company ahead of time to determine copays, deductibles, and non-covered services for you.  File an insurance claim on your behalf.

If You Have...	You Are Responsible For...	Our Staff Will...
<b>HMO with which we are <u>not</u> contracted.</b>	Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
<b>Point of Service Plan or Out Of Network PPO</b>	Payment of the patient responsibility— deductible, copay, non-covered services—at the time of the visit.	<p>Call your insurance company ahead of time to determine out of network benefits, copays, deductibles, and non-covered services.</p> <p>File an insurance claim on your behalf.</p>
<b>Medicare</b>	<p>If you have Regular Medicare, and have not met your \$110 deductible, we ask that it be paid at the time of service.</p> <p>Any services not covered by Medicare must be paid at the time of the visit.</p> <p><u>If you have Regular Medicare as primary, and also have secondary insurance or Medigap:</u> No payment is necessary at the time of the visit.</p> <p><u>If you have Regular Medicare as primary, but no secondary insurance:</u> Payment of your 20% copay is requested at the time of the visit.</p>	File the claim on your behalf, as well as any claims to your secondary insurance.
<b>Medicare HMO</b>	All applicable copays and deductibles at the time of the office visit.	File the claim on your behalf, as well as any claims to your secondary insurance.
<b>Worker's Compensation</b>	<p><u>If we have verified the claim with your carrier</u> No payment is necessary at the time of the visit.</p> <p><u>If we are not able to verify your claim</u> Payment in full is requested at the time of the visit.</p>	Call your carrier ahead of time to verify the accident date, claim number, primary care physician, employer information, and referral procedures.
<b>Worker's Compensation (Out of State)</b>	Payment in full is requested at the time of the visit.	Provide you a receipt so you can file the claim with your carrier.
<b>Occupational Injury</b>	Payment in full is requested at the time of the visit.	Provide you a receipt so you can file the claim with your carrier.
<b>No Insurance</b>	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.
<b>Outstanding Balance</b>	Collections costs, Court costs, and Attorney Fees (if needed).	Work to collect total amount due. If delinquent after 60 days, turn you over to collections.

## **Contracted Insurance Plans**

Medicare  
Medicaid  
Blue Cross/Blue Shield  
Office of Group Benefits  
Aetna  
Employee Benefit Services  
FARA  
Benesys  
Humana/Choice Care  
American Life Care Network  
Benefit Management Services  
Vantage  
PPO Plus  
Benefit Administrative Services  
Blue Bell Creameries  
Private Healthcare Systems

\*\*If you belong to an insurance company that is NOT listed above, please contact our office at (318)255-1212 to verify if we are in network.

## **Surgery**

If your physician recommends surgery, you will be escorted to his Surgery Coordinator. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it.

The Surgery Coordinator will request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. A cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be explained by the Surgery Coordinator.

*I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.*

*I authorize my insurance benefits be paid directly to Lincoln Surgical Associates, APMC.*

*I authorize Lincoln Surgical Associates, APMC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Printed Name**