Office and Financial Policy

Welcome to Hillcrest Family Medicine. We want to thank you for choosing us as your healthcare provider. In an effort to provide the best care possible, we would like to take a moment and explain a few of our policies.

Updating Information:
Please be sure we have the most current demographic and insurance information at all times. Filing claims with incorrect information delays processing and increases patient liability. Therefore, at check-in you will be asked to inform us of any changes to your demographic and insurance information. If you fail to give us updated insurance information at the time of your appointment, we will not be able to file your claim to the correct company after 30 days from the date of your visit.

Appointments:
We understand that your time is valuable and we do our best to keep the schedule running smoothly and on time. Out of respect for all patients we ask that you be on time for each appointment. Any patient who arrives greater than 15 minutes past their scheduled appointment time will be asked to reschedule for a different day.

Should an emergency arise, we ask that you be patient as we do our best to handle the situation and return to seeing patients as scheduled. Unfortunately, it may be necessary for us to reschedule appointments unexpectedly. Should this occur, we will do our best to notify you as soon as possible and reschedule you at the next earliest time.

Should you need to cancel or reschedule any appointment, please contact the office as soon as possible; 24 hours notice is appreciated. Failure to notify the office prior to your scheduled appointment 3 times could result in being dismissed from the practice. A $25.00 no show fee may also be assessed. This fee is not payable by your insurance company and therefore will not be filed with insurance; the patient will be responsible for payment.

Preventative vs. Problem Visit:
A preventative service, such as a well woman exam or physical, is a service provided to screen for various illnesses and diseases. A problem/sick visit is one when the patient has a specific concern, symptom, or complaint. Due to insurance carrier’s requirements, we cannot see you for both preventative service and a problem/sick visit on the same day.

Medicare:
We are always glad to see Medicare patients. In an effort to help avoid unexpected expenses we would like to explain a little about Medicare. One, Medicare only covers certain preventative services and applies frequency limitations to those services. Medicare will cover the collection of a pap smear and the breast and pelvic exam once every 24 months. If you choose to have these services more frequently, you will be responsible for payment. Keep in mind, whatever, Medicare does not approve, then any supplemental insurance will not cover either. Secondly, Medicare never covers the office visit portion of an annual well women exam; the patient will be billed for this charge. Third, we are required by federal law and Medicare guidelines to charge all patients the same amount; therefore, we cannot discount any amounts not covered by Medicare. Should you have concerns about payment for your services, please speak with our billing department prior to your visit.

Non-covered Services:
A non-covered service is any service that is denied by your insurance carrier due to benefit descriptions or limitations, policy exclusions, or pre-existing waiting periods. Non-covered services will be the responsibility of the patient and payment is due at the time of service. Please contact your insurance carrier and inquire about any service that may be non-covered. If you receive a service that is considered non-covered by your insurance plan, you will be expected to make payment in full for all charges.

Insurance:
We are contracted with multiple insurance companies. Some insurance companies have special programs that allow for better benefits for you as the patient. While our physicians may be contracted with the insurance company in general, they may not be a preferred provider under these special programs. We suggest you always verify with your insurance carrier to confirm there is nothing specific about your plan that would exclude our physicians.

Payment:
Our office attempts to verify all patients' insurance benefits prior to their appointment. Any co-pay, deductible, and/or co-insurance are due at the time of service. We will give you the best estimate possible based off of your benefits quoted. Please keep in mind, sometimes benefits are misquoted by your insurance carrier; however, we must collect based off their explanation of benefits. Once your insurance carrier has finalized your claim, we will make any necessary adjustments to your account.

Outstanding balances are due in full upon receipt of statement.

Claim Filing:
We are obligated to file claims for you with all contracted insurance companies. We will be happy to file your claims to non-contracted companies with the exception of Medicaid. Should you have Medicaid Insurance, please let us know and we will provide you a copy of the charges associated with your visit so you may file a claim on your own.

Secondary insurance plans can be of great assistance in the payment process. We will file deductible and co-insurance amounts to any secondary insurance you provide us; co-pays will not be filed to your secondary. Also, if you have multiple insurance carriers, please make sure each carrier is aware of the other and you provide us with accurate information. An insurance carrier in the patients name is always primary; you may not choose which carrier to use as primary vs. secondary.

Insurance Billing and Payment:
In an effort to reduce patient financial liability, it is sometimes necessary for our billing department to appeal claims. In doing so, it may also be necessary to involve other agencies such as the Texas Medical Association and/or the Texas Department of Insurance. By signing this policy, you agree to allow us to release certain demographical and medical information to these agencies in order to secure payment. Please be assured we will only release information that is absolutely necessary.

Referrals/Authorizations:
Should your insurance require a referral to another provider, please allow our office 72 hours to complete the referral. Under certain circumstances, you may be required to come and see the physician before a referral can be completed.

Phone Calls:
While every phone call is important and we strive to answer all calls, there may be situations where the medical assistant cannot answer the call as they are with other patients. If this occurs please leave a detailed message and all calls left by 3:00PM that day will be returned that day.

Prescriptions:
When you are due for a prescription, please contact your pharmacy and have them send over a refill request. Once we receive the refill request, we will review the prescription and either approve the prescription or notify you that we are unable to approve the prescription and will discuss your options with you at that time. Please allow 48-72 hours for prescription refills to be completed.

Certain insurance plans require prior authorizations in order for specific prescriptions to be filled. If your insurance plan requires prior authorization, we will work as quickly as possible to complete it. Please keep in mind that some insurance plans take up to 3 weeks to complete their authorizations.

Labs:
When you have blood work, pap smear, biopsies and/or cultures done we will send the specimens to an outside lab. Our preferred lab is LabCorp. Should you prefer an alternate lab, we will do our best to accommodate; however, you must inform the lab tech prior to having your blood drawn. All lab tests will be billed by the laboratory. We do our best to forward the most current insurance information we have on file with each specimen. Occasionally this information does not forward properly. Should you receive a bill from the lab due to incorrect information, simply call the lab and provide your current insurance information. We do not have access to your laboratory billing account.

Responsible Party/Minors:
The patient will be considered as the responsible party for payment purposes. If the patient is under the age of 18, the parent/guardian authorizing care (i.e., bringing the patient in) will be responsible for payment of services. If a patient is over 18, regardless of who holds the insurance policy, the patient will be responsible for payment of services.

Refunds:
Should your insurance process your claim differently than quoted or expected, any refund due to you will be issued only after all outstanding claims have been processed and there are no upcoming appointments within the next 3 months. This policy is designed to reduce administrative work associated with refunding money and subsequently billing for new balances. A patient with an account credit greater than an estimated amount due for a new service should not have additional monies collected, or only the difference between amount due and credit balance.

Returned Payment:
Payment is accepted in the form of cash, money order, and/or credit card. Should a payment be returned for any reason, including but not limited to, insufficient funds, stop payment, or closed account, the patient will be liable for the original amount plus any associated NSF fees. Our current NSF fee is $25.00.

After Hours Care:
In the event of an urgent matter, you may reach the physicians after hours by dialing our phone number and leaving a message on the physician's voice mail. Please keep in mind that if your situation is an emergency, you need to call 911 and/or go to the nearest hospital emergency room. Do not page Dr. Bhargava or Dr. Pepperell for an emergency. The hospital will be able to reach them for you once you arrive at the hospital. Furthermore, if you are only calling on an urgent matter and want a call back, please leave your name and number for the physician. Additionally, if your phone does not except private/blocked calls, you will have to enable your phone to receive those calls for the physicians to call you back.

Medical Records:
If you require copies of your medical records, please allow two weeks for processing the request. Furthermore, if you are requesting your records for yourself, there is a fee which must be paid prior to the records being copied and mailed. According the Texas State Board of Medical Examiners, the fee is $25.00 for the first twenty pages and $0.50 for each additional page. As a professional courtesy, we will provide records to another physician one time at no cost. If you request your records sent again within 6 months, charges as defined the Texas State Board of Medical Examiners will apply.

I have read, understand, and agree to the information and policies set forth in this agreement. I further agree that a photocopy of this agreement or an electronic signature is as valid as an original.

Patient's Name (Print)____

Signature____ Date___________________________

Parent/Guardian Name (Print)____

Signature____ Date___________________________