



# Peninsula Pain Clinic, PLLC

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## Financial Policy

Patient Name \_\_\_\_\_

In order for our patients to understand our financial policy and billing practices, and because we want you to fully understand your financial obligations, we're providing you with the following information. We welcome the opportunity to discuss any aspect of our financial policy. Please ask to speak with our biller. Each area below must be initialed by the patient.

### **Financial Responsibilities and Policies:**

1. Patients must provide the billing office with accurate billing information and copy of all insurance cards. It is your responsibility to notify us immediately if there is a change in billing information and to furnish us with a copy of your new insurance cards. If we must resubmit claims due to inaccurate billing information, we will charge an additional \$7.50 re-billing fee. \_\_\_\_\_
2. Patients are responsible for determining if their insurance requires a referral from their primary care physician. Prior to your initial visit, you are responsible for confirming that our office has a referral on file. If your claim is denied by your insurance for lack of a referral, you will be responsible for payment in full. If we must resubmit claims, we will charge an additional \$7.50 rebilling fee. Our office will request all follow-up visit referrals. \_\_\_\_\_
3. Patients must also notify the office if they change primary care physicians. If you need a referral from your insurance, you are responsible for contacting your new PCP and then confirm that our office received the referral. If we must resubmit claims due to invalid referral or invalid PCP information, we will charge an additional \$7.50 rebilling fee. If the claim is denied, you will be responsible for payment in full. Our office will request all follow-up visit referrals. \_\_\_\_\_
4. Patients are responsible for knowing the amount of their co-payment and making it at the time of their visit. If we must bill you for a co-pay, there will be an additional billing fee of \$15.00. \_\_\_\_\_
5. Our billing department will only bill your primary and secondary insurances. Once these claims have been processed and posted to your account, you are responsible for any remaining balance due. If an insurance company denies your claim, and you feel this denial is incorrect, it is your responsibility to resolve the problem and notify the billing department of the result. If your insurance company mails payment directly to you, you must forward the payment to your billing department as soon as you receive it. Failure to do so may result in termination from our practice. \_\_\_\_\_
6. If you have NO INSURANCE, payment is due in full at the time of your visit. Our bookkeeper can advise you as to your financial responsibility. If payment arrangements are not fulfilled, you may be terminated from the practice. \_\_\_\_\_

7. We have participating provider contracts with Medicare and various commercial insurance carriers. We accept their contracted rate as the allowed amount. Patients are still responsible for applicable co-payments, co-insurances, and deductibles. If you want to know if we contract with your insurance, check with your insurance carrier. \_\_\_\_\_

8. MEDICARE PATIENTS: If our doctors recommend a service be performed, and we believe it will not be covered by Medicare, we will provide you with an “Advanced Beneficiary Notice” explaining why we feel you need this service and advising you that you will be responsible for payment if Medicare denies. You will then be able to decide whether or not you want to have the service performed. \_\_\_\_\_

9. There will be a charge assessed to my account in the event of a no-show (failure to arrive for scheduled appointment) or the cancelation of an appointment with less than one business days’ notice (24 hour notice). (\$75 (office visits) / \$100 (procedures)) \_\_\_\_\_

10. We accept cash, Visa, MasterCard, and money orders as means of payment. If a payment is returned for non-sufficient funds, or cancelled an additional finance fee of \$50.00 will be added to your account and full payment is due upon receipt. \_\_\_\_\_

11. We reserve the right to forward delinquent accounts to a collection agency and you will be terminated from our practice. \_\_\_\_\_

If you have any questions or issues with our financial policy, our Administrator has the ability to override any decision.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient

Thank you,

Richard Sabin  
Administrator,  
Peninsula Pain Clinic