HANOVER FAMILY PRACTICE ASSOCIATES, LLC
FINANCIAL POLICY

Thank you for choosing us as your primary care providers. We are committed to providing you with quality and affordable care. As a part of the ongoing treatment and care of our patients we require that you be seen at least once per calendar year in our office for a preventive visit or a Routine office visit to remain in good standing with the practice. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any necessary questions you may have, and sign our financial policy acknowledgment form. A copy will be provided to you upon request.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

CHARGES

Charges for the professional care you receive from our providers while you are in the hospital are billed separately from the charges for the use of the hospital facilities. Your monthly statement from us will include the charges for the doctor's in-hospital care. These should be paid in the same manner as charges incurred in our office.

Feel free to discuss fees and treatment at any time. We want all of our patients to understand our charges and medical care. We want you to be satisfied that they are reasonable, equitable and appropriate. Complete frankness on the part of both patient and doctor is the best guarantee of mutual understanding.

Check your statement carefully when you receive it. We try to be as accurate as possible concerning your financial records, but we do make mistakes. The more promptly you notify your doctor's office of an error on your account, the sooner we can correct it.

Please assist us in verifying your insurance claim information and the claim will promptly be filed with your insurance carrier.

NON-COVERED SERVICES

Please be aware that some-and perhaps all- of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.

MEDICAL INSURANCE

There are many types of insurance's with varying amounts of benefits. Please remember that we have no control over what amount your insurance company will pay. At your request, we will provide you with a "walk-out statement" that you may use in filing to your insurance carrier. We do file insurance claims with certain private insurance companies, Medicare and Pennsylvania Medical Assistance. The payment of your account balance remains your responsibility, and we will continue to bill you and

expect payment from you even if your insurance company disputes your claim. We are not able to negotiate a disputed claim with your insurance company. We expect you to pay our service at the front desk unless we participate with your insurance plan or other arrangements have been previously made. The responsibility for payment of the account always remains with you. We will send you a monthly statement of your account with all unpaid charges for the current month listed and itemized.

PROOF OF INSURANCE

The front desk personnel will ask you for a copy of your insurance card at every visit to assure that your insurance carrier has not changed. This process is in place to assure that you the patient are not billed for something that your insurance carrier should be compensating your provider. We must obtain a copy of your driver's license as well. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim.

COVERAGE CHANGES

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you fail to provide us with the correct insurance information, you will be responsible for the balance of the claim.

SELF PAY DISCOUNT

We do offer a self-pay discount to patients without insurance coverage. The discount will only be applied if you pay at time of service.

FINANCE CHARGE

You will incur a finance charge of $10.00 if your balance is carried over for more than 30 days after your carrier for services rendered by our Practice has processed your claim. All patient statements have this message documented on them as a courtesy to remind you of our finance charge policy.

RETURNED CHECK

There will be a $50.00 fee for any returned checks.

FINANCIAL RESPONSIBILITY AT THE TIME OF THE SERVICE

All co-payments, deductibles, co-insurances and fees for non-insured services are due at the time of your appointment.

COMPLETION OF MEDICAL DOCUMENTS

There is an administrative fee for completing forms that take our providers away from providing care to other patients, such as DMV, sports physicals, FMLA, leave of absence etc. Most forms require five to six working days to research your information and complete the form. You will be called when the form is complete and ready for pick up. If you have questions regarding a form or fee, please ask the front desk personnel. The fees are also posted in the office.

REQUEST OF MEDICAL RECORDS

There is an administrative fee for processing a medical records release when the patient requests the record be forwarded to them vs. submitting directly to another provider.

MISSED APPOINTMENTS

I understand that if I or any member of my family misses an office appointment, I will be contacted and asked if I would like to reschedule and reminded of the practice policy charging for missed appointments. Notification will be via telephone or letter. If I do not wish to reschedule, I will be asked if I can be assisted further in my medical care.

If the patient is judged to have a potentially serious medical problem, then the case should be discussed with the physician on location within 48 hours of the original appointment.

A second missed appointment within a 12-month period will result in being charged a missed appointment fee.

A third missed visit will result in discharge of my family and me from the practice.

All phone calls to or from a patient related to missed appointments must be documented in the patient's record on the practice management system and/or in the patient's medical record.

AFTER HOURS CHARGE/WEEKEND CHARGES

You may incur an after-hours charge if you are treated after 5:00pm during the week or on the weekend.

MULTIPLE CO-PAYS

You may be responsible for two (2) co-pays by your insurance carrier if multiple evaluation and management services are performed on the same day.

WAIVER

You may be asked to sign an ABN (Advanced Beneficiary Notice) or a Waiver of Liability form if a service that you are receiving typically is a non-covered service.

Truth and Lending Statement (aka) Patient Payment Plan

We now have an option for our patients to keep a credit card on file when setting up payment plans. We will keep your credit card on file in a safe and secure location and will only process your credit card within the realms of your request. Please contact your Dr.'s office or the billing department for additional information.

If you need assistance or have questions, please contact The Billing Office (717)633-6513. I have read and understand the HFPA Financial Policy. I agree to assign insurance benefits to the HFPA Practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature or Authorized representative: **Date:**

_____________________________________ ______________________

Jlm 07062010
Revised Jlm 06172012
Revised Jlm 03192020
Revised jlm 12232020
Revised jlm 02112022

CREDIT CARD POLICY

You agree to allow us to keep a credit card, debit card, or HSA card on file which will be used to pay all current charges and all future charges incurred after your insurance has paid or if you do not have health insurance. These methods of payment will be stored in a secure location within our computer system and will be used only for paying balances after insurance processes the visit or if you do not have health insurance on file with our practice.

Your credit card will be processed 30 days after the release of your patient statement. You will have 30 days from the date of the statement to dispute the charge. In the event that your card expires or changes it is your responsibility to update this information with us. Please call the billing department at (717) 633-6513 for assistance with any questions or problems.

I, ________________________ agree to have the card information listed below stored by Hanover Family Practice Associates for the sole purpose of paying my account balance after my insurance processes the claim or if I do not have health insurance. All deductibles, co-insurances, and non-covered services not paid at the time of the visit will also be charged to this card.

I agree to the above and understand that if I do not comply, I will be required to make payment in full to the practice within 30 days, or the account is subject to our finance charge of $10.00.

Current Health Insurance Carrier: _____________________________________

Card Holder Name: ____________________________________

Card Holder Address: ___________________________________

City: ____________ State: ________ Zip: _________

Card #________________________________ EXP Date: _________________ CVV: ___________

Family Members or dependents that you agree to the Credit Card Policy for:

Patient Name: ____________________ Guarantor #_______________

Patient Name: ____________________ Guarantor #_______________

Patient Name: ____________________ Guarantor #_______________

Patient Name: ____________________ Guarantor #_______________

Patient Name: ____________________ Guarantor #_______________

Signature of Patient, Parent, Guarantor, POA: Date:

______________________________________ ________________