Financial Policy

We would like to thank you for choosing All Pro Health as your healthcare provider. Our staff and providers are committed to providing you with the best possible medical care. We are sure you understand that payment for this healthcare is your responsibility. The following information outlines your financial responsibilities related to payment for professional services.

Required at Check-In:

1. Verify Personal Contact Information.
2. Present Current Copy of Insurance Card.
3. Present Current Drivers' License.
4. Payment of any Outstanding Balance

5. Payment of Current Visit: We will verify your coverage at each visit and collect copays and deductibles based on current benefits. If we are unable to verify coverage, or you do not have out of network benefits, you will be considered self-pay and will be responsible for your visit.

For Our Patients With No Medical Insurance (Self Pay):

If you do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit.

For Our Patients With Medical Insurance Benefits:

We are out of network with all insurances with the exception of Medicare. This means that in order for your insurance to cover our services, you must have out of network benefits. For those insurances that allow you to assign payment of benefits directly to us, we will accept the assignment. In the event that your insurance sends payment to you for our services, you will be responsible for sending that to us.

Our billing office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Co-Payments, Coinsurance, and Deductibles:

Additionally, you may have coinsurance and/or deductible amounts required by your insurance carrier. Any outstanding balance on your account, after adjusting for all of your insurance's responsibilities, will be billed to you.

Waiver Of Patient Responsibility:

It is the policy of the practice to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with the practice's Financial Hardship Policy.

Non-Covered And Out Of Network Services:

Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility.

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.

Nonpayment:

All patient responsible balances that remain delinquent after 90 days, with no response to our requests for payment, may result in you being discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Patient statements:

Our practice strives to be as “green” as possible. To that end, statements will be sent via electronic communication. We also offer the option to maintain a credit card on file with a PCI compliant system.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I, _____, have read and understand All Pro Health Financial Policy and I Agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Patient’s Signature Date