# MONTICELLO MEDICAL ASSOCIATES

1 South Creek Drive, Ste. 102, Monticello, KY 42633 PH. 606.348.3365 Fax 606.348.8496

## FINANCIAL POLICY

Thank you for choosing Monticello Medical Associates as your health care provider. Payment of your bill is considered part of your treatment and a clear understanding of our financial policy is important to our professional relationship.

We will bill your insurance as a courtesy when you present with a copy of your current insurance card. If you do not have your insurance card, full payment is due at the time of service. We accept cash, local checks, credit, and debit cards. There will be a $50.00 charge for returned checks. If payment is not received from your insurance company any balance will be your responsibility.

To help ensure accuracy we ask that your current insurance information be provided to us at **each** visit. We do not guarantee that your insurance will pay any portion of your bill. We do require co-payments, deductibles, payments for non covered services and any percentage responsibility you have under your insurance plan to be paid at the time of your visit.

### SELF PAY:

A minimum of $80 must be paid at the time of service for the Doctor visit. If you have any additional charges such as Laboratory, Injections or X-Ray services those must also be paid at the time of service.

### SLIDING FEE:

We offer a sliding fee discount program that is open to all patients regardless of any insurance coverage. The amount of discount is based only on annual household income and number of persons living in the household. An application for the program is required and must be completed annually.

### COMMERCIAL / PPO:

**All co-payments or deductibles are due at the time of service.** You are responsible for verifying what your insurance plan will cover and that we are providers for your plan.

### WORKERS COMPENSATION:

If you are here because of a work-related injury, we will require information regarding your employers Workers Compensation insurance. We require authorization / verification from your employer authorizing your treatment. We must have the following: YOUR EMPLOYER'S NAME, ADDRESS, PHONE NUBMER, DATE OF ACCIDENT, WHAT TYPE OF INJURY YOU RECEIVED, BILLING ADDRESS, AND CLAIM NUMBERS. We will call your employer to verify the information you provide. If payment is not received, the balance is your responsibility.

### MOTOR VEHICLE ACCIDENTS:

WE ONLY FILE AUTO INSURANCE FOR LOCAL COMPANIES (THEY MUST HAVE AN OFFICE IN WAYNE COUNTY). If you are here for an Auto related accident, we must have authorization / verification from the Auto Insurance prior to treatment. You must provide the following: NAME OF INSURANCE COMPANY, ADDRESS, CLAIM NUMBER, AGENT/ ADJUSTER NAME, DATE OF ACCIDENT, POLICY HOLDER NAME AND DATE OF BIRTH OF THE AUTO INSURANCE.

### BANKRUPTCY:

If you file bankruptcy and our bill is part of your bankruptcy you will need to have bankruptcy court send us a copy including the date the case was filed. We will hold the bills for a period of 6 months or until we get a determination from the bankruptcy court. You will still be responsible for payment in full at the time of visit of any charges dated after the date of your filing.

**We do not get involved in negotiating payment for divorce orders for medical bills. Whichever parent brings the minor child in for treatment will be responsible for payment of the bill regardless of your divorce decree.**

**PATIENT NAME: _____DATE OF BIRTH: _____**
**PATIENT / PARENT / GUARDIAN SIGNATURE: _____ DATE: _____**

**REV: 10/17/2023-kdt**