
Patient Financial Policy

Thank you for choosing River Oaks Primary Care PLLC as your healthcare provider. We are dedicated to delivering exceptional care and to making your experience with us as smooth and stress-free as possible. An important part of this relationship is your clear understanding of our Patient Financial Policy. Please carefully review the following policies regarding financial responsibility for services rendered.

Insurance Participation

We participate in most major insurance plans, including Medicaid and Medicare. However, if you are insured by a plan in which we do not participate, full payment is required at the time of service. If your insurance coverage cannot be verified at the time of your visit, you will be required to pay in full until we can confirm your coverage.

It is your responsibility to ensure that River Oaks Primary Care PLLC is listed as your Primary Care Provider (PCP). If we are not listed as your PCP and your insurance does not cover the visit, you will be responsible for full payment. If you choose to cancel your appointment due to an insurance issue, you will incur a \$10 administrative fee for late cancellation.

Copayments, Deductibles, and Coinsurance

All copayments, deductibles, and coinsurance are due at the time of service. This requirement is part of your agreement with your insurance company. Failure to collect these amounts at the time of service is considered non-compliance with the law. We accept Mastercard, Visa, American Express, cash, and checks.

A \$35 fee will be assessed for any returned check, payable by cash or money order, in addition to the amount of the check. After a returned check, you may be placed on a cash-only basis for future visits.

Non-Covered Services

Some services may not be covered by your insurance plan or may not be considered medically necessary by Medicare or other payers. In these cases, you will be responsible for paying for these services in full.

Proof of Insurance

All patients are required to complete the patient information form before being seen by a provider. We must obtain a copy of your current insurance card and driver's license to verify your insurance coverage. Failure to provide accurate and timely insurance information may result in the patient being responsible for the balance of the claim.

Claims Submission

We will submit insurance claims on your behalf and assist with the claims process. However, your insurance provider may request additional information directly from you, and it is your responsibility to respond to such requests promptly. Ultimately, the balance of any claim is your responsibility, whether or not your insurance company pays the claim. Your insurance benefit is a contract between you and your insurance provider; we are not a party to that contract.

Coverage Changes

If your insurance coverage changes, please notify us before your next appointment so we can update your information and help you receive the maximum benefits available under your plan. If your insurance company does not pay your claim within 45 days, the balance will be billed directly to you.

Nonpayment

Accounts that remain unpaid will receive up to three statements. If payment is not received, we reserve the right to withhold future services until payment is made. We offer payment plans and are happy to work with you to accommodate your financial situation.

If no payment is received within six months of the date of service, you may be discharged from our practice and notified by letter to seek alternative care. During the 30-day notice period, we will provide emergency care only. If payment is not received or no arrangements are made within those 30 days, your patient status will be terminated.

Self-Pay Accounts

Self-pay patients are those without insurance, those with insurance plans in which we do not participate, and those without an insurance card on file. We do not accept payment through attorney letters or contingency-based payments. It is the patient's responsibility to verify whether our office participates in their insurance plan. If there is a discrepancy with insurance information, the patient will be considered self-pay unless proven otherwise.

Minors

The parent or guardian of a minor is financially responsible for the cost of care and will receive all billing statements. A signed release may be required to treat unaccompanied minors.

No-Show and Cancellation Policy

It is your responsibility to cancel or reschedule appointments at least 24 hours in advance. **Same-day cancellations without a valid emergency reason incur a \$10 late cancellation fee. Missing an appointment without prior notice incurs a \$25 no-show fee.**

After three consecutive no-shows, you will be required to schedule an appointment with the provider to evaluate your situation. During the evaluation, the provider will review your medical history, attendance, and compliance with payments and care recommendations to determine whether continued care is appropriate. If you do not respond to the request for an evaluation within 30 days, your status as a patient will be terminated, and you will receive a letter notifying you of this decision.

Patient Responsibility for Payment

Regardless of any arrangements you may have with other parties, if you are 18 years of age or older and receiving treatment, you are ultimately responsible for payment. We will not bill any other individual or party outside the terms of your health insurance. Our practice strives to offer the best care possible at reasonable and customary rates for our area.

We appreciate your understanding of our financial policies. Our goal is to provide high-quality healthcare while making the payment process as clear and manageable as possible. If you have any questions or concerns about this policy, please do not hesitate to contact our office.

Respectfully,

River Oaks Primary Care PLLC

Financial Policy — Patient Acknowledgment

Please sign and return this page to the front desk.

Patient Name (please print)

Date of Birth

I, the undersigned patient, acknowledge that I have read and fully understand the River Oaks Primary Care PLLC Financial Policy and agree to adhere to its terms and conditions.

Patient or Legal Representative Signature

Date