Patient Payment Policy

Mid Ohio DDA (MODDA) has modified its patient payment policies to keep abreast of the new High Deductible Health care plans and the Health Savings accounts. You will be asked to sign this new policy. If you have any questions please contact our billing department at 614-575-2600.

1. **Proof of Insurance.** Your insurance policy is an agreement between you and your insurance company. Knowing your insurance benefits is your responsibility **NOT MODDA.** If you supply us with accurate insurance information, we will bill your insurance plan for you. Questions about your benefits should be directed to your insurance company. All patients must complete a new patient information form before seeing the doctor. We will ask for a copy of your driver's license and current valid insurance card(s) as proof of insurance. If you cannot provide proof of coverage you will be treated as a self pay patient and responsible for 100% of your bill. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to your billing information.

   Non-contracted insurances: If we are not contracted with your insurance company, your out-of-pocket costs may be greater than originally anticipated. We will do our best to give you an estimate of your costs but the final amount due will be determined by reimbursement from your insurance company **and you will be responsible for the additional costs.**

2. **Deductibles and Health Savings Accounts.** Please be aware that some insurance plans require large portions of the balances to be paid by you the insured. **We require payment at the time of service.** You may receive a call from our billing office to assist you in payment arrangements.

3. **Co-payments. All co-payments must be paid at the time of service or your appointment will be rescheduled.** Per our contract with your carrier we are **required** to collect these co-payments.

4. **Non-covered services.** Please be aware that any services determined by your insurance carrier as "non-covered" not reasonable or not necessary become your responsibility.

5. **Claims submission.** We will submit your claims and provide reasonable assistance in getting your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request in a timely manner. **Remember you are responsible for your charges whether or not your insurance company pays your claim.**

6. **Uninsured.** We will attempt to work with patients that do not have insurance coverage. We will develop a payment arrangement schedule between the patient and the practice. If payments are not made as agreed upon you may be discharged from the practice and sent to collections.

7. **Nonpayment.** Patients who have unpaid balances will be required to make payment arrangements prior to scheduling an appointment**.** If you fail to pay your portion of your bill, we may refer your account to a collection agency and all fees incurred will be the responsibility of the patient. In addition you may be discharged from this practice. If this occurs, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physicians will only treat you on an emergent basis.

8. **Missed appointments.** Our policy is to charge $25.00 for missed office appointments or appointments which you fail to keep without 48 hours notice. There is a $75.00 charge for a missed procedure without 72 hours notice. These charges will be your responsibility and billed directly to you. Your insurance will not pay them. Please help us to serve you better by keeping your regularly scheduled appointment.

9. **Returned Checks.** Any returned checks are subject to a $20.00 service fee. Any returned check must be resolved before any future appointments can be scheduled.

I have read and understand the payment policy and agree to abide by these guidelines. I understand that I am responsible for any portion of my bill that is not covered by my insurance company.

______________________________	______________________
Print Patient Name	Date
______________________________	______________________
Signature of Patient or Responsible Party	Relationship to Patient