Eastern Shore
DEVELOPMENTAL CLINIC

OFFICE POLICIES

28150 North Main St. Suite A
Daphne Al 36526
Phone: 251.625.2400 • Fax: 866.845.2618

Patient Name: _____

We are committed to providing you with quality and affordable health care. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicaid. If you are not insured by a plan we do business with, payment in FULL is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card of any kind, payment in FULL for each visit is required until we can verify your coverage. We will verify your insurance coverage at the time of scheduling. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. Non-covered services. Please be aware that some of the services you receive may be non-covered by your insurers. This would be very rare. You must pay for these services in FULL at the time of visit or at the time of billing.
4. Proof of insurance. All patients must complete our patient information form before seeing the provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract and we were not a party to making that contract.
6. 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 your Medicaid has lapsed or if you have an Inactive Medicaid Referral it is your responsibility to obtain a new one prior to the next visit or the visit will be cancelled because we cannot bill without either of these.
   If a commercial insurance company does not pay your claim in **30 days**, the balance will automatically be billed to you.
7. Nonpayment. If your account is over **90 days** past due, you will receive a letter stating that you have **20 days** to pay your account in full. Partial payments will not be accepted unless otherwise negotiated in advance one week of the appointment with the provider. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you may be notified by regular and certified mail that you have 30 days to find alternative care.
8. Confirming Appointments. All appointments must be confirmed 48 hours before the scheduled time. If it is not confirmed, the appointment will be canceled without notice.
9. Missed Appointments. Our policy is to charge **$50** for missed appointments that are not canceled within forty-eight hours prior to the appointment this includes no show appointments. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
10. Please note that all payments for scheduled payment plans will be ran on the 1st of the month. If there is a change in payment method, please contact the office to update this information.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

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

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date