Payment Policy

Thank you for choosing Evershine Med, PLLC, as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop a payment policy. Please read it, ask questions you may have, and sign it in the space provided. A copy will be provided upon request.

Insurance: We participate in most plans, including Medicare. 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, payment in full is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If your insurance company does not pay your claim in 45 days, the balance may automatically be billed to you.

Copayments and deductibles: All copayments and patient responsibilities 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 copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayments and deductibles at each visit.

Non-covered services: Please be aware that some, and perhaps all, of the services you may receive may not be covered or may not be considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full.

Proof of insurance: All patients must complete our patient information form before seeing their healthcare provider. We must obtain a copy of your drivers license and valid proof of health insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the charges.

Claims submission: Evershine Med, PLLC, will submit your claims and assist you in a reasonable fashion help get your claims adjudicated. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company. Any balance after coordination of benefit, including Medicare, is your responsibility. Evershine Med, PLLC, submits a claim for your visit to your insurance as a courtesy however we are not responsible for your insurance's adjudication.

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: If your account is over 90 days past due, you may receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. 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 occurs, you will be notified by mail that you have 30 days to find alternative medical care. During that 30-day period, our medical providers will only treat you on an emergency basis. In a true emergency, you will be instructed to call 911.

Cancelations and Missed Appointments: Each time a patient misses an appointment without providing proper notice, another patient may be prevented from receiving care. Our office will be assessing a 'missed appointment fee' to patients who do not provide at least a 24-hour notice prior to missing an appointment. This fee must be paid in full prior to any additional services being rendered. The fees are as follows: first occurrence - $75, second occurrence within 6 months - $100, third occurrence within 6 months - $150 and possible dismissal from the practice.

Forms completion: Evershine Med, PLLC, will be assessing a fee for any forms which need to be completed by our providers outside of the time allotted for their office visit.

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 guardian Date