WILLIS-KNIGHTON HEALTH SYSTEM

Payment Policy
Willis−Knighton
Network Physicians

Patient Name: _____ Date of Birth: _____

Payment arrangements are understood and agreed upon by the patient and provider prior to services being rendered.

Willis−Knighton Health System participates with and accepts most insurance plans. **Patients are required to furnish proof of insurance at the time of service.** As a courtesy to our patients, we will be happy to file the insurance claim(s) for services rendered by any of the 80+ providers participating within the Willis−Knighton Physician Network.

Monthly statements are generated and mailed to patients/guarantors to make them aware of any outstanding balance after insurance coverage has been exhausted. **Any outstanding balance is considered the guarantor's responsibility regardless of insurance coverage.**

An account will be deemed delinquent after 90 days from the date of service or from the date services were denied or paid by the insurance carrier.

Annual deductible amounts will be the obligation of the guarantor. If the patient has met his/her deductible for the current year and can verify this with an Explanation of Benefits from his/her insurance carrier, the remainder of the patient responsibility (such as 20% for most insurance plans) will be due at the time of visit.

Co−payments for HMO's, PPO's, and other managed care plans must be paid at the time of service. Balance billing patients for their co−pays is a violation of many managed care contracts and will not be allowed. **Co−payments will be collected at check−in before the physician sees the patient.** If the patient does not have the co−pay at the time of visit, the patient may reschedule the appointment in order to meet the co−pay requirement.

Should the patient or responsible party express an inability to pay, alternate payment plans and assistance are available upon request. The physician and/or clinic manager must approve monthly payment plans and discounts. Patients must agree in writing to the payment plan prior to seeing the physician.

My signature below verifies that I have read and understand the payment policy outlined above.

_____ _____
Patient (if over 18 years of age) Date

_____ _____
Guarantor (if patient is under 18 years of age) Date