COPLIN
HEALTH SYSTEMS
www.coplinhealthsystems.com

Patient Financial Policy

Thank you for choosing ***Coplin Health Systems*** as your health care provider. We appreciate that you have entrusted us with your health care, and we are committed to providing you with the best patient care possible. Your clear understanding of our Patient Financial Policy is important to our provider-patient relationship. Please ask if you any questions about our fees, our policies, or your responsibilities.

1) **Insurance:** Your health insurance policy is a contract between you and your health insurance company. Please note that it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals and/or pre-authorizations. You should be knowledgeable of any deductibles, copayments and/or coinsurance.
   a) We participate in most insurance networks including Medicare and West Virginia Medicaid.
   b) We accept all West Virginia-based insurances at all locations, and Ohio Medicaid at Parkersburg, River Valley, and Southern Local Schools Wellness Center.
   c) Please contact your insurance company with any questions you may have regarding your coverage.
   d) If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
2) **Copayments and Deductibles:** The arrangement to pay copayments and deductibles is part of your contract with your insurance company.
   a) We accept payment by cash, check or credit cards.
   b) All copayments must be made at the time of service, unless other arrangements have been made prior to the appointment.
   c) If you have a high deductible policy and know your deductible has not been met, you may pay a deposit towards the deductible at the time services are provided. The deposit amount will be credited to the amount your insurance applies to your annual deductible.
   d) Note: Failure on our part to collect copayments and deductibles from patients may be considered fraudulent. Please help us in upholding the law by paying your copayment at each visit.
3) **Proof of Insurance:** All patients must complete our daily visit slip to update demographic information before being seen. We must obtain a copy of your current insurance card to provide proof of insurance. Failure to provide us with the correct insurance information in a timely manner may result in you being responsible for the balance of the claim.
4) **Insurance Claims Submission:** We will submit your claims (primary and secondary insurances), and assist you in any way we reasonably can to help get your claims paid.
   a) Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.
   b) We will send a statement to you for any balance remaining after your insurance pays.
   c) Please be aware that the balance of your claim is your responsibility if your insurance company denies your claim, and notifies us that it is billable to you.
5) **Uninsured (Self-Pay) Patients:** In order to minimize wait time at check-out, we will collect a deposit for the services provided that day. The deposit is expected to be paid at the time of service.
   a) The deposit for a New Patient visit is $104.
   b) The deposit for an Established Patient visit is $60.
   c) The deposit amount most likely will not cover the total amount of charges for your visit, but will cover a portion. The deposit amount is intended to be a partial payment, not an estimate of the total charges for the visit.
   d) Once all charges are posted to your account, a statement will be sent to you indicating the balance due (total charges minus the deposit amount).

Approved 08-24-19

6) **External Services:** You may be billed separately for diagnostic services, such as lab work, or other specialty services which are not performed at a Coplin Health System site.
7) **Payment for Services:** It is your responsibility to make timely payments on your account for the services you receive. If you find that you are unable to pay the balance due in full, please contact us to set up a payment arrangement. We want to work with you to keep your account in good standing, but it is up to you to let us know you need assistance.
8) **Sliding Fee Discount Program:** Coplin Health Systems offers a discounted/sliding fee schedule for patients who do not have insurance or are underinsured (high deductible and/or no secondary insurance). There is an application process for this discount program, and eligibility is based on income and family size. *No one will be denied access to services due to inability to pay*. Please contact any of our clinics for information and an application for the Sliding Fee Discount Program.
9) **Returned Checks:** A $25.00 fee will be charged for all returned checks.
10) **Missed Appointments (No Show):** Missing your scheduled appointment may impact your health. It may also keep another patient from being seen since the appointment time was reserved for you.
    a) A patient is considered a "No Show" when:
        i) The patient does not contact the office to cancel a scheduled appointment within two (2) hours of the appointment time
        ii) The patient does not show up for their medical appointment without notifying Coplin Health Systems
    b) Consequences for "No Shows":
        i) New patients will be not be allowed to schedule an appointment if they have "No Showed" for two (2) scheduled appointments for the initial visit. The patient will receive a letter of dismissal from Coplin Health Systems.
        ii) Established patients who "No Show" three (3) times in a calendar year will receive a letter of dismissal from Coplin Health Systems. At the beginning of each year (January 1st) an established patient's "No Shows" will be reset to zero for those patients with two (2) or less "No Shows" the previous year.
    c) The patient, the patient's guardian, or legal representative has the right to appeal the "No Show" status.
    d) A patient who is dismissed due to the "No Show" policy can still be seen for Acute Care services only.

Coplin Health Systems is committed to providing the best treatment for our patients. Our prices are representative of the usual and customary charges for our area. The terms of this financial policy may be amended or updated as needed. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the Financial and No Show policy, and agree to abide by its guidelines:

_____ _____

Printed Name of Patient or Responsible Party **Printed Patient Name (if Different than Responsible Party)**

_____ _____

Signature of Patient or Responsible Party **Date**

Approved 08-24-19