# EAST CAROLINA MEDICAL ASSOCIATES – Financial & Cancellation Policies

The staff of ECMA would like to thank you for choosing us to provide you with quality care. Please understand that payment of your bill is considered a part of your treatment. This financial policy of the clinic is designed to clarify the payment policies as determined by the management of the clinic. Payment, according to the policies below, is due at time of service. We accept cash, electronic checks, money orders, or credit card.

**1. Co-pays**

All co-pays are expected when services are rendered. Any co-pay not paid at time of service will be charged a fee of five dollars, ($5.00). Every month statements will be sent out the first of the month. Any account with an outstanding balance will be charged a five dollar ($5.00) fee.

**2. Forms**

All patients must complete the Patient Registration form and provide complete insurance information as well as a copy of your insurance card(s). We can only bill your insurance plan(s) if we have complete and accurate information. If you cannot supply us with sufficient insurance information at the time of the visit, we will consider the entire bill to be the patient's responsibility and payment in full will be due at time of service.

**3. Patients without Insurance**

Payment in FULL is due at time service, unless other arrangements have been made. Account balances are required to be paid in full prior to next office visit.

**4. In-Network and Out of Network**

We are in-network with several insurance companies. Upon initial check-in, your insurance will be verified and explained to you. We may not be in-network with your insurance carrier. If we are not contracted with your insurance carrier you will be required to pay according to your plan (including co-pay, co-insurance and deductible). It is your responsibility to know the benefits provided by your insurance carrier.

**5. Return Checks**

If a check is returned for in-sufficient funds, we will not accept any further checks from you. Payment must be made by cash, credit card or money order. There will be a return check fee of twenty-five ($25.00) that will be due immediately. This will be required to be paid as well as the amount of the check prior to the next office visit.

**6. Missed Appointments/Cancellations**

Please ensure that you will contact our office to cancel any appointments in advance at least 24 hours for office visits, and 48 hours for procedures. This will allow us enough time to fill the appointment as needed. Repeated missed appointments may result in no show charges to your account.

***Cancellation Policies***

Office Visit: 24 hours notice is required to cancel an office visit appointment. The following fees will be charged for no-show appointments with in less than 24 hours notice:

| | |
|---|---|
| New Patient Visit | $100 |
| Established Patient Visit | $75 |

Procedures: 48 hours notice is required to cancel a procedure appointment. The following fees will be charged for no-show appointments with in less than 24 hours notice:

| | | |
|---|---|---|
| $100 | Stress Test | Carotid Doppler |
| | Echocardiogram | Lower Extremity Doppler |
| | Stress Echo | |
| $150 | Nuclear Stress Test | |

**7. Medical Record Requests and Forms**

There will be a fee charge for any medical records released to the patient. We will however forward the records to another physician at no charge. There will be a fee for all forms that the patient requests the physician to fill out regardless of reason. These fees will be determined at the time of request.

**8. Collections Policy**

(a) After attempts to bill patient/insurance for 90 days, (b) failure to provided correct insurance information, (c) undisclosed financial hardship or (d) failure to comply with executed in office payment plan, we reserve the right to forward your account to a collection agency. Once a patient's account has been forwarded to a collection agency, the patient has thirty, (30) days of continued care with our practice to enable the patient to find another provider or pay their balance in full if they wish to continue treatment with this facility. Once an account has been turned over to a collection agency all payments must be paid directly to the collection agency regarding the outstanding account.

I understand that failure to comply with the above mentioned policies, my account may be charged as this notice outlines in section 6. I further understand that these fees must be paid prior to my next office visit.

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Printed Name

_____ _____

Patient/Guardian Signature Date

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