



FINANCIAL POLICY

Thank you for choosing Music City Primary Care for your primary care needs. Our physicians and staff are committed to delivering quality care and service to you. Understanding our financial policy is an important part of our professional relationship. Below is an explanation of our payment, cancellation, and no-show policies. Please make yourself aware of these policies as you sign off on them.

IN-NETWORK INSURANCE

Music City Primary Care (MCPC) participates in most major insurance plans. To ensure that MCPC is in network with your insurance, please contact your insurance carrier. It is your responsibility to provide MCPC with accurate, up-to-date insurance information.

- MCPC is currently in network with United Healthcare, Medicare, Cigna (with the exception Connect/EPO Network), Cigna Healthspring, Aetna, Amerigroup, TennCare, Medicaid, Blue Cross and Blue Shield, UHC Community Plan, Humana Medicare plans, and Bright Health.
- At this time, MCPC cannot see Oscar, or PHCS/Multiplan patients including but not limited to: Blue Care (Medicaid), Blue Care Plus dual eligibility Medicare/Medicaid Plan, Cigna Connect/EPO, WellCare, Humana, Ascension Complete, and BCBS Medicare Advantage PPO.

COPAYMENTS, DEDUCTIBLES, AND COINSURANCE

Your insurance co-payment is due at the time of your visit. Nail biopsies and in-house pathology services will be charged along with the office visit. If further testing is required to obtain an accurate diagnosis, your specimen will be sent to an outside laboratory, where additional charges may apply. If you are unable to pay your co-payment at the time of your visit, we will reschedule your office visit. If we determine that you have a deductible or a co-insurance amount due, you will be asked to pay \$75 at your visit. We do our best to have accurate collections, but please note that your co-pay/deductible are subject to determination by your insurance company. As a courtesy, our office will file your claim with your insurance company and initiate correspondence with the purpose of getting you the maximum coverage your insurance allows.

SELF-PAY FEE SCHEDULE

MCPC is out of network with certain insurance providers. It remains the responsibility of the patient/policyholder to know your insurance coverage, including out-of-network benefits. MCPC does not file out-of-network benefits. MCPC has a flat fee schedule for out-of-network patients. These fees are subject to change without notice. MCPC will provide information regarding the fees upon request. If you have not provided medical insurance, you hereby confirm that you do not have insurance to be billed and understand that payment is due at the time of service.

HEALOW PAY (Online Payment)

MCPC encourages patients to pay through Healow Pay (an online payment system) when insurance claims are filed. Healow Pay helps reduce the amount of paper statements sent. After a claim for services rendered has been submitted and fully processed by your insurance company, any balances listed as "Patient Responsibility" can be paid through Healow Pay. Patients will receive an email and text message with a link to pay. The transaction will try and process for 4 consecutive business days. If the payment fails or declines, the claim will remain declined, and the patient will receive a statement in the mail.



INSURANCE BALANCES

MCPC will submit claims to in-network insurance on behalf of the patient as a courtesy. The balance becomes your responsibility if we do not receive payment or resolution from your insurance company within 60 days of filing the claim. The patient is responsible for non-covered medical services.

APPOINTMENT CANCELLATIONS AND NO-SHOWS

We understand that situations arise in which you must cancel your appointment. It is required that if you must cancel your appointment, you provide **24 hours notice**. Providing advanced notice is a courtesy to your provider and allows another patient to be seen. Without notification, you are subject to a late cancellation fee or a no-show fee. We understand that special unavoidable circumstances may cause you to cancel within 24 hours prior to your appointment. Fees in this instance may be waived, but only with management approval.

_____ (initial) I understand that office appointments which are canceled with less than 24 hours notice are subject to a **\$35.00** cancellation fee.

_____ (initial) I understand that if I no-show an appointment, I will be charged **\$35.00** to reschedule an office appointment and to reschedule a procedure appointment.

CHARGEBACKS AND RETURNED CHECK FEES

There will be a **\$25.00** fee in addition to the original amount owed if your check is returned from the bank or your credit card charge is charged back to MCPC.

_____ (initial) I understand that a **\$25.00** fee will be incurred for returned checks and credit card chargebacks.

PAST DUE BALANCES

Past account balances must be settled prior to being seen for a subsequent appointment.

_____ (initial) I understand that past due balances must be paid prior to being seen for a subsequent appointment.

GUARANTOR INFORMATION AND PAYMENT FOR PATIENTS UNDER THE AGE OF 18

Guarantor information is responsible party information. A guarantor (or responsible party) is the person held accountable for the patient's bill and services rendered. A patient presenting for care that is 18 years of age or older is always the guarantor for bills relating to their care, except in an incapacitated adult. College students 18 years or older are always the guarantor for services they receive. MCPC does not bill absent parents for payments due at the time of service. The adult presents the minor for care to the responsible party and guarantor.

NOTE: If the parent presenting the minor brings a divorce decree stating that the other parent is financially responsible for the child's medical bills, the guarantor is changed to the parent designated in the divorce decree. The financially responsible parent's information is required before the patient can be treated, including full name, billing address, phone number, email address, and phone number.



Guarantor name: _____

Relationship to patient: _____ DOB: ____/____/____

Mailing Address, if different than patient:

Street Name: _____ City: _____

State: _____ Zip: _____

Email Address: _____ Phone Number: ____/____/____

I certify that I have read the financial policies of Music City Primary Care and I agree to abide by these policies.

Signature _____ Today's Date: ____/____/____
(Patient or Parent/Guardian)