Patient Financial Policy

Arete Family Medicine - Anchorage (AFM-A) is committed to providing information and quality services for all of our patients. As part of our commitment to you, AFM-A feels it is important you understand your financial responsibility and have a good understanding of your insurance plan. This understanding would include knowing your yearly deductible, out of pocket maximum, co-insurance and co-pay, and preferred lab, X-ray and provider.

1. Insurance: We participate in most insurance plans, but not all. If AFM-A is not in-network with your insurance plan, we will still submit claims on your behalf and will process payments by your insurance company. Any unpaid insurances balances then become your responsibility and your payment will be required by your statement due date. It is your responsibility for knowing which lab, pathology, radiology, or facility that you are required to use. AFM-A cannot be held responsible for any fees/co-pays that you incur when an improper facility is used for testing and/or procedures. Please contact your insurance company with any questions you have regarding your coverage.

2. Co-payments and deductible: If you are insured by a plan with a co-payment for the office visit, it will be collected at check-in. If you have a deductible, co-insurance plan or outstanding balance, we will collect that at check-out. If do not know your co-insurance amount, AFM-A will expect a standard 20% at the time of service. In the case that not all charges are entered prior to check-out, please be aware that the uncollected patient responsibility will still be required by your statement due date. Failure on our part to collect co-pays and deductibles/co-insurance from patients can be considered fraud. Please help us in upholding the law by paying your portion at each visit.

3. Proof of insurance: On arrival, we will verify your current insurance at every visit. If you are unable to provide correct insurance information in a timely manner, you may be responsible for the balance of the claim. It is imperative to update our office of any changes in insurance policies to keep our records accurate.

4. Claims submission: We will submit your claims and assist in any way we reasonably can to help get your claims paid. Your insurance may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balances of your claims are your responsibility.

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5. Non-covered services: Not all services provided by our office are covered by every plan. Any services determined not to be covered by your plan will be your responsibility. You will be asked to sign a waiver for non-covered services that your insurance may deem unnecessary or experimental.

6. Uninsured patients: Should you find yourself to be uninsured, we are able to offer a pay-in-full service rate. Please be advised that the rate is only good when the charges are paid at the time of service. If the charges are not paid at the time of service, the rate will be removed and payment of the full charge will be expected before the next visit.

7. Nonpayment: Payment for services received is the responsibility of the patient or guarantor, regardless of insurance status. If your account is over 90 days past due and no payment arrangement has been made with our office, your account may be referred to a collection agency and/or subject to patient dismissal from AFM-A.

8. Missed appointments: Any appointments not canceled within 24 hours prior of scheduled time OR arrives more than 10 minutes late will be considered a “no-show”. Patients who no-show three (3) times within a 12-month period could be dismissed from the practice. Please help us serve you better by keeping your regularly scheduled appointments.

I have read the AFM-A Patient Financial Policy and agree to abide by its guidelines.

I hereby assign to AFM-A any insurance or other third-party benefits available for healthcare services provided to me. I understand that AFM-A has the right to refuse or accept such benefits. If these benefits are not assigned to AFM-A, I agree to forward AFM-A all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

Printed Name: ______________________________ Relationship to patient: _____________

Signature: _________________________________ Date: ___________________