



AVA HEALTH LLC  
FINANCIAL POLICY

Ava Health appreciates your confidence in selecting us for your healthcare needs. We are committed to providing you with the highest standards of care, with compassion and integrity. We want our fees and billing services to be honest and fair as well. We have worked hard to maintain your access to care by accepting most insurances here in Missoula, and we have contracted with a local billing office to be responsive to your questions in a timely fashion.

## Understanding Your Financial Obligation

**Non-Insured Patients:** All office procedures are to be paid in full at the time of service. If you are unable to pay in full at the time of service, prior to your appointment, you will need to speak with our billing office.

**Insurance:** Our billing office will submit primary and secondary insurance claims for you –subject to your having given us current information prior to the service being provided. For your convenience, we have tried hard to be able to accept most insurance companies here in Missoula. Policy coverage varies from one insurance plan to another, as do the “usual, customary and reasonable” fee that various insurance plans have established. Our fees are accepted by most plans, but occasionally one of our patients is notified that the amount for our service exceeds “UCR FEES”. Our contractual arrangement is with you, our patient, not your insurance company. Should there be a dispute related to the service provided or the charge for that service, the settlement of that dispute with your insurance carrier is between you and your insurance carrier.

Our office is not involved in the settlement of such disputes. The final responsibility for the services provided to you is yours.

**Fees:** Our charges for services – including office visits and procedures – are based upon the severity and complexity of your injury or illness as well as the time spent treating you. Our fees are based upon the Resource Based Relative Value scale and Relative Value Units. These are both assigned by the Federal Government Centers for Medicare & Medicaid services and can be found in the Federal Register each year. Please don’t hesitate to inquire about the charges for services.

**Payments:** Charges are payable at the time treatment or service is given. Regardless of your medical insurance coverage, our office relies on you to settle your account. For your convenience, we offer the following payment options:

1. Payment in full.
2. Payment of the portion your insurance will not cover (co-payment or deductible), on the day service is provided.
3. Payment of balance in full upon receipt of your statement.

If other arrangements are needed please talk to our billing office prior to receiving service. Payments can be taken by cash, check, VISA, DISCOVER, or MASTERCARD, including HSA cards.

**Proof of Insurance:** In order for us to bill your insurance, we require that you provide us with the proof of insurance in the form of an insurance card.

**Medicare:** Our office is proud to be able to accept Medicare insurance for you. There are some services that our not covered by Medicare that may be recommended to you. If we think it is likely that Medicare will not cover services, we will notify you prior to you receiving such services.

**Workers’ Compensation & Medical Vehicle Accident Claims:** This office has chosen not to take cases involving Workers’ Compensation or Motor Vehicle Accident Claims. Keeping your primary care as our focus is important to us. We will be happy to provide you with referrals to providers who take these cases.

**No Show/Late Cancellation Fees:** Any patient who fails to arrive for a scheduled appointment without canceling the appointment less than 24 hours prior to the scheduled time is considered a “no-show”. There is a charge of \$25 for failure to show. A patient who fails to present for a scheduled appointment three 3 times is considered a chronic no-show patient and is dismissed from the Practice.

**Delinquent Balance Appointments:** Any patient with a delinquent balance, in excess of 90 days will be required to contact our billing office for a payment plan prior to future services.

**Medical Forms/Records:** Our office is happy to fill out all medical forms for you. A fee of \$10 per form is required prior to the form being completed. There will be no additional fee charged for the forms that are filled out **during** scheduled office visits. One copy of your medical records will be provided to you for free for your personal use. Additional copies, or any copy for non-personal use, will be charged according to state law at \$15 plus \$.50/ page.

**Collections:** Our practice will make an effort to settle all delinquent accounts before an account is sent to an outside collection agency. In the event an account is sent to the collection agency, a collection fee will be added to your account and the entire delinquent balance will be reported on your credit report. I understand that in the event any unpaid balance is placed for collections with any third party collection agency a fee of 50% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and any other fees so stated elsewhere. The authorized fee of 50% and the additional costs and charges listed above represent the actual costs incurred to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from the signer’s failure to pay as specified in this agreement.

**Returned Checks:** A \$30 fee will be charged on all check returned with insufficient funds.

**Refunds:** In the event of an overpayment on your account, a thorough review of the account will be conducted to determine the cause of the credit balance. Our office will make every effort to handle all refunds to the patient or insurance company.

**Billing Office:** Questions can be directed locally to **Monida Billing Solutions at 406-829-2388**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_