



FINANCIAL POLICY:

As the healthcare insurance industry increasingly drives the development of a “managed care” environment for both patients and doctors, it can easily become an overwhelming process for a patient to complete all the insurance forms. To help you determine what information and actions will be required on your part, we’ve outlined below some of the requirements of several types of insurance carriers. Our Front Desk and Billing staff will be happy to assist in answering any further questions you may have regarding this information.

HMO/MANAGED CARE/ Participating programs: You are responsible for paying co-pays at the time of the visit and for obtaining any referrals/authorizations your plan may require before the visit. You are responsible to obtain your referral letter prior to your office visit. As per your agreement with your carrier, if you fail to take these steps you will be responsible for the entire payment. Otherwise, we will submit all charges and follow-up with your carrier for payment.

NO-FAULT/WORKERS COMPENSATION: You will need to provide our office with all information required to properly submit charges. Without this information, the fees mandated by the State of Michigan will be charged to reflect our private fees and you will be responsible for payment. Some no-fault carriers have deductibles on medical charges for which the patient is responsible. If you have private insurance with which we participate and obtain any referrals/authorizations, we will submit on your behalf and bill you for any unpaid balance.

MEDICAID: You will need to provide our office with your Medicaid ID Card prior to your visit along with a letter from your referring physician. If you are assigned to a HMO/Managed Care program through Medicaid, you will be responsible for obtaining all authorizations as outlined in the HMO/MANAGED CARE/Participating program section above. Please be aware, we do not participate with all of the Medicaid Programs through the State of Michigan.

NON-PARTICIPATING CARRIERS: You are responsible for full payment of charges at the time of the visit if we do not have a participation agreement with your insurance carrier. If you provide our office with the necessary billing information for the visit, we will submit the charge on your behalf to your carrier for reimbursement to you. You are responsible for following up with your insurance carrier regarding any unpaid claims and/or appeals.

LIABILITY: Carriers usually send payment to the patient or to the patient’s attorney if one has been retained. Our policy does not allow us to hold accounts that are pending resolution of any liability or litigation issues. We do not bill attorneys. If you provide a letter from the liability carrier indicating they accept full responsibility and will send payment, we will submit our bill to them on your behalf. Otherwise, you may either have charges submitted to your private carrier and pay for the services and obtain reimbursement upon resolution settlement.



SELF-PAY: If you are uninsured, you are responsible for payment in full at the time of service, unless prior arrangements have been made with the Billing Department. If you are unable to pay in full and need to discuss payment options available to you, you must contact our Office Manager at (313)-277-6700, Monday – Friday 9:00 am – 4:00 pm.

If you require further clarification of any of the policies described here, please contact our office directly at the number noted above. Thank you for your cooperation in this matter.

We accept cash, checks, MasterCard, Visa, Discover, and American Express.

I have read and or been advised to read the entire financial policy

Signature of Guarantor _____ Date _____

Patient Name: _____

Staff Initial _____

Authorization of Treatment/Assignment of Benefits/Release of Information

I hereby authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I hereby authorize my physician to release any information regarding my medical condition, including disability or employment related information concerning my claims for my insurance carrier(s), authorized agent(s) or attorney(s) for the purpose of validating and determining benefits payable in connection with my incurred medical expenses. I understand that my authorized representative or I may receive a copy of this authorization request. I also authorize direct payment of benefits to my attending physician.

Date: _____

Signature of Guarantor/Patient: _____