

# Catalyst Medical Center

## Patient Payment Policy

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Catalyst Medical Center strives to ensure a clear understanding of your financial responsibility with respect to the medical services we provide. These policies apply to all procedures and departments.

**Co-Pays:** We require payment of co-pays at the time of service, and reserve the right to refuse treatment.

**No Insurance:** If you have no insurance, we collect \$150 for your initial office visit, \$75 on your follow-up visit. (Note: there may be additional charges to your office visit if scopes or procedures are required.) We collect a partial payment on elective procedures at the time of service. A representative will contact you before your elective procedure to arrange payment in full or to set up a payment plan.

**Payments:** We accept cash, Visa, MasterCard, Discover and Care Credit. We also accept payment by check and debit cards. We hold a credit card number on file to reserve an appointment. Catalyst Medical Center will send patients accounts to collections for balances not paid after receipt of two statements unless you make payment arrangements with our billing office. We reserve the right to require payment for services to be made at or before the time of service.

**Allergy patient payments:** See Catalyst Medical Center's waiver form for Sublingual Drops.

**Outstanding balances:** We may refuse to see patients with balances over \$250, and who are not making regular payments on the balance. If you have an unpaid balance at the end of a billing cycle, we apply a \$5 late payment fee to your account. If you make a payment and it is insufficient to pay both the late payment charge and the principle amount due, we apply your payment to the late payment fee due and then we apply the remaining amount to the principal. In the event that your account is placed for collection, a collection fee will be added to your account, along with any attorney fees and/ or court costs that may be necessary for recovery of the outstanding balance. In the event of an NSF check, there will be a \$30 NSF charge added to the balance due.

**Cancellations:** We charge your credit card on file if you do not call and cancel your appointment within the timeframes below. Notification allows the doctor to see another patient who needs to be cared for that day.

**Regular appointments:** We charge \$25 to your credit card if you do not call and cancel your appointment 24 hours ahead of time for all regular scheduled appointments.

**Allergy testing appointments:** We charge \$150 to your credit card if you do not call and cancel your appointment 48 hours ahead of time.

**Cosmetic/Skincare appointments:** We charge the full amount of service (up to a \$150 maximum) to your credit card if you do not call and cancel your appointment 24 hours ahead of time. Payment is due for cosmetic and skincare at the time of service.

**Cosmetic and self-pay deposits and payments:** We require a \$500.00 nonrefundable deposit due at the time the surgery is scheduled. We require payment for self-pay procedures one week before the surgery is performed.

**Claim Filing:** We happily file your claim with your insurance company as a courtesy. Please keep in mind that payment remains your responsibility. We do not enter disputes over insurance benefits. We bill insurance in accordance with all federal, state and other contractual requirements in cases where we have an agreement or we are a participating provider. We expect payment in full from you if your insurance company delays processing of your claim for over 60 days. You agree to pay any portion of the charges not covered by insurance. If your insurance company sends payments directly to you, send or drop-off the payment to Catalyst Medical Center, and we will apply it to your account.

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**Medicaid:** We file Medicaid patient's claims for the states of North Dakota and Minnesota. If you have assistance from another state, you will be responsible for payment of the services you receive and the filing of your own claims. It is the Medicaid patient's responsibility to receive referral.

**Workers Compensation:** If your claim is denied you will be responsible for payment in full.

**Preauthorization:** Most insurance companies require preauthorization before you have a surgical procedure. Failure to obtain preauthorization may result in your insurance company refusing to pay your claim. Any refusal of payment by insurance for this reason is your responsibility.

**Dependants:** You are responsible for payment of services rendered to your dependents on your account. In cases where a written court order allows payment for medical costs associated with a dependent, it is the responsibility of you to obtain reimbursement from the other party involved.

**Referrals:** If you see a doctor that is out of network or if you use an insurance company that requires a referral, you are responsible for obtaining it from your primary care clinic or physician. Failure to obtain it may result in a lower payment or no payment from the insurance company or no benefits from your insurance company and you will be responsible for payment.

**Surgery:** Upon request, the Surgery Coordinator will explain a cost estimate, which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan. The amount of which depends on your coverage and deductible amount.

**Forms/Letters/Medical Records:** We may bill \$25 for forms or letters that a provider completes on your behalf. We charge \$25 copy fee for medical records requested for personal use.

*I authorize Catalyst Medical Center to keep my signature on file and to charge my credit card (held in our secure system) for:*

1. Charges associated with appointments that are not cancelled within the timeframes listed above.
2. Charges associated with payment arrangements. Contact billing office to make payment arrangements.

**Attestation Statement:**

*I have read, understand, and agree to the above Catalyst Medical Center Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I acknowledge that these policies do not obligate Catalyst Medical Center to extend credit.*

*I authorize my insurance benefits be paid directly to Catalyst Medical Center.*

*I authorize Catalyst Medical Center to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.*

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Signature of Patient (or responsible party if minor)

\_\_\_\_\_  
Date