Steven A. Crews, DO, PA
Registration Form
Financial Policy, Assignment of Insurance Benefits and Privacy Practice Notice Verification

Financial Policy-Payment is expected when services are rendered and upon receipt of statement of account from our office.

We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them and you are required to pay a co-payment and or payment due toward your deductible and co-insurance at the time of your visit.

CO-PAYS are collected prior to you being seen. Patients who pay a co-insurance or have not met their deductible will make payment at check in and remaining balance at checkout. Charges are estimated from the actual visit level only and may not include payment for testing or other procedures performed that has not been finalized at check out. Additional payment may be due for these services once we receive notice from your insurer. Your insurer will notify you of your responsibility in an EXPLANATION OF BENEFITS (EOB) statement. Please read your EOB carefully. You will usually receive your EOB before we get our notification of payment. We collect a $25 dollar no show fee for confirmed appointments.

We may request payment of outstanding balances prior to you being seen even if you have not been mailed a statement.

Financial Responsibility

Keep in mind that your insurance policy is basically a contract between you and your insurance company. If your insurance company does not pay the practice within a reasonable period (120 days from date of billing), we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you usually within 30 days of notification/payment.

We participate with a select number of insurers and are participating Medicare Part B providers. Contracts are subject to change without notice. We do not participate with all plans that those companies provide. The insurers limit network participation as part of their cost saving program. It is your responsibility to keep your benefits information current and accurate. We verify insurance information before you are seen in order to allow us to determine your financial responsibility.

If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. If you have questions regarding coverage for any procedure or care we provide you after you sign in, it is your responsibility to ask for a written advanced beneficiary notice (ABN) before accepting services. We will get an ABN for services we feel may be denied but not for non covered services.

We do not participate with discount card programs. We will be happy to provide you with a receipt or HCFA 1500 claim form so you can file your claim. Copies of your statements are available online via the patient portal.

Additional Important Billing Information

Please notify us if you have a secondary or additional insurance coverage so that we may bill your secondary insurance. By signing in and consenting to care you understand that you are responsible for payment of non-covered services that you receive in the office. If you fail to provide us with accurate information before you are seen, you have had lapse in insurance, or misrepresent your coverage, you responsible for payment of the visit.

We reserve the right to charge late fees, collection fees, and fees relating to court costs for collection of payment due. If your account is transferred to a collection agency, additional fees may be added by the collection agency.

Statements are mailed to your address of record. If you move or have a change of address, please notify our office. Failure to update your records may cause your account to be sent to collections due to non-payment.

If your account is in arrears and we have sent you a statement, we may additionally contact you by phone as a courtesy to notify you of your outstanding balance.

If you have any questions regarding your bill, please contact the office by phone or in writing. Our biller is available at extension 102. The best time to call is between 2 pm and 5 pm.

We accept the following credit card payments- Discover, Master Card, and Visa and American ECpress. You may pay by phone by calling the office. We currently do not have online payments through our portal. Checks will deposit within three business days. There is a $35.00 NSF fee for any checks returned for non-sufficient funds. Credit card payments will avoid possible NSF occurrences. Refunds are processed within 30 days of receipt of notification of payment from your insurer. We will apply any refund amounts to outstanding balances prior to forwarding refunds. (over for additional information)

NAME: DOB:

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Name: DOB

Acceptance of Financial Policy and Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Dr. Steven A. Crews, DO, PA for services rendered by him in person or under his employ and supervision. I understand that I am financially responsible for any balance not covered by my insurance and the information in the financial policy as noted in this document.

Signature:_____ **Date**: _____

Patient Name (please print)_____

Relationship: (please circle) SELF PARENT GUARDIAN HEALTH CARE SURROGATE

PLEASE complete the Item below…..

Privacy Practice Notice
I have had an opportunity to review a copy of the Steven A. Crews, DO, PA "Notice of Privacy." I acknowledge that PHI (Personal Health Information) may be released in compliance with the practice policy for care and billing purposes. By signing this form I understand the policy and its limitations and that it will be in effect the duration of my care by Steven A. Crews, DO, PA or his designated agent. Please notify staff if you would like a copy of the Privacy Notice. I understand that my HIPPA release is authorization to release personal health information related to my care to include, electronic prescription records and will allow release of personal health information as necessary via electronic communication using secure HIPAA compliant clearing houses, exchanges or portals or via paper form using first class mail.
I understand I will be asked to revalidate my HIPAA annually and receive or access updated HIPAA policy at that time.

Signature:_____ Date: _____

Patient Name (please print)_____

Relationship: (please circle) SELF PARENT GUARDIAN HEALTH CARE SURROGATE

NOTES:

NAME: DOB: