FINANCIAL POLICY

Thank you for choosing Mat-Su Surgical Associates for your surgical healthcare needs. We are committed to providing you the best surgical healthcare available. You are required to read and sign our financial policy prior to any treatment.

NO SHOW POLICY – any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least a 24-hour notice will be considered a 'No Show' and charged a $75.00 fee.

INSURANCE - As a courtesy to our patients, we bill and participate with most insurance types. It is your responsibility to know your insurance benefits. If you are unsure of your benefits, please contact your insurance carrier with questions. If you do not provide proof of insurance, you will be expected to pay in full at the time of service or make payment arrangements with our billing staff. You will be considered a self-pay patient until the insurance information is provided to our office.

- **PROOF OF INSURANCE –**We must obtain a copy of your insurance card(s) and a copy of a photo ID for billing. Failure to provide us with the correct information will result in the inability to assist you in filing insurance claims.
- **CLAIM SUBMISSION –**As a courtesy to our patients, we will submit claims. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their requests.
- **CO-PAYMENT/CO-INSURANCE/DEDUCTIBLE** – Co-pays are due at time of service. Co-pays, co-insurance, and deductibles are part of your contractual obligation with your insurance company and are patient responsibility.
- **SCREENING COLONOSCOPY-** Prior to scheduling a screening colonoscopy, you will have a pre-op exam in the office. The office exam is NOT part of the procedure and will be billed to your insurance carrier. This office visit may be subject to your deductible or co-insurance depending on your insurance plan.
- **NON-COVERED SERVICES** – Please be aware that some or all of the services provided may not be covered or not considered reasonable or necessary by some insurers. It will be your responsibility to pay for these services.
- **CHANGE IN COVERAGE** - If your insurance coverage changes, please notify us as soon as possible, so we can make the appropriate changes to help you receive your maximum benefits.
- **USUAL AND CUSTOMARY –** Our prices are representative of the usual and customary charges for our geographic area. You are expected to pay in full for any balance after insurance.

NON-PAYMENT – If your account is thirty days past due, you may be contacted by our billing department asking for payment in full or to make payment arrangements. If your balance is unpaid after three months, we may refer your account to Cornerstone Credit Services, a collection agency.

CREDIT BALANCE – A refund will be generated to the responsible party if an account has a credit balance over $10.00. Balances less than $10.00 will be retained and applied to future balances unless a refund is specifically requested.

SELF-PAY ACCOUNTS – You are required to bring a minimum of $200 toward the initial office visit. If the total balance due is more than you are able to pay at time of service, reasonable payment arrangements may be made by signing a self-pay financial agreement.