West Omaha Family Physicians, P.C.

17030 Lakeside Hills Plz, Suite 130, Omaha, NE 68130
Phone: (402) 758-5150
Fax: (402) 758-5158

Financial Policy

Thank you for choosing West Omaha Family Physicians, P.C. The following is a statement of our financial policy. Please understand that payment of your bill is part of your treatment and care.

All patients must complete and accept our financial policy before receiving treatment. We will require seeing your insurance card at every visit and will request a copy of your insurance card every six months. Obtaining necessary information upfront will enable our billing staff to bill your insurance both timely and appropriately. Patients are responsible to notify our office in the event of insurance or other demographic changes.

Payment Methods: We accept CASH, CHECK, VISA, and MASTERCARD. Payment plans may be arranged on an individual basis with our Billing Manager.

Definitions

- Co-Payment: A fixed dollar amount set by your insurance contract that is *required* to be paid at the time of your office visit. In the event that you arrive without your co-payment, the front desk staff will be happy to re-schedule your appointment.

- Deductible: An annual dollar amount established by your insurance plan that is deducted from insurance benefits. This amount is your obligation.

- Co-Insurance: A percent set by your insurance plan that is deducted from your insurance benefits. If you do not have a co-pay amount, then a co-insurance amount of 20% will be charged to you at the time of your visit (Medicare/Medicaid patients will not be charged this at the time of service). Medicare patients will be billed after Medicare pays.

- Self-Pay: A patient that does not have any valid health insurance. You will be asked to pay for services at the time of your appointment.

MVA Policy: We will NOT file your insurance claim to your motor vehicle insurance. We will collect your personal insurance information at the time of service to file to if payment from your MVA is not received within 60 days of service. If insurance has not paid this claim within 90 days, the amount due will become the patient's responsibility.

Personal Injury (Liability): We require a financial arrangement be established for payment in full at the time of service for personal injury cases. We will file a claim with your personal insurance if you wish, but you will still be required to do the above financial arrangements.

Work Related Injuries: We will file Worker's Compensation claims with your employer's Workers Compensation insurance carrier. Written or telephone authorization is required from your employer and/or insurance company prior to treatment. If prior authorization is not obtained, you are responsible for full payment at the time of service. If your company's workers compensation carrier has not paid your account in full within 90 days of your date of service, the balance will be transferred to your account and it is your responsibility to pay in full by the statement due date.

Returned Checks: A $20.00 service fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to pre-pay in full by cash or credit card for additional services.

Collection Accounts: All services after an account has been given to a collection agency will be on a CASH ONLY basis. All co-pays and deductible will be collected at the time of service. If you are unable to comply your appointment will be rescheduled.

I agree to be fully responsible for all lawful debts incurred by myself for services received from West Omaha Family Physicians, P.C. whether covered by my insurance or not.

I have read, understand, and agree to the Financial Policy. I understand that charges not covered by insurance, as well as any applicable co-payments and/or deductibles, are my responsibility.

I authorize my insurance benefits to be paid directly to West Omaha Family Physicians and to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____
Signature of Patient or Legal Guardian

_____
Patient's Date of Birth

_____
Patient's Name (print)

_____
Today's Date