

**MIAMI BEACH COMMUNITY HEALTH CENTER**  
**OPERATIONAL POLICIES & PROCEDURES**  
**DEPARTMENTAL POLICIES & PROCEDURES**

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibilities for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**Patient Payment Policy**

1. **INSURANCE** – We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **CO-PAYMENTS & DEDUCTIBLES** – All co-payments must be paid at the time of service and are subject to MBCHC's sliding –fee scale payment policy. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **NON-COVERED SERVICES** – Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers.
4. **PROOF OF INSURANCE** – All patients must complete out patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **CLAIMS SUBMISSION** – We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim may be your responsibility whether if your insurance company does not pay your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **COVERAGE CHANGES** – If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **NONPAYMENT** – If your account is over 90 days part due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. If you have difficulty keeping your account paid in full, as the Miami Beach Community Health Center Financial Counselor to provide to you a partial payment plan for your review. If it is determined that you have the ability to pay and you refuse to pay you will be denied services.
8. **MISSED APPOINTMENTS** – Our policy is to charge \$15.00 for missed appointments. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. If you cancel your appointment within 24 hours of the time of your appointment, you will not be charged.

Our practice is committed to providing excellent medical care. We provide that care at a discounted rate based on the Federal Poverty Guidelines. The rule under which the Bureau of Primary Health Care administers our funding requires us to make every effort to obtain the appropriate payment from our patients.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

**I have read and understand the payment policy and agree to abide by its guidelines.**

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Signature of patient or responsible party

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Date