Sitka Medical Center

907-966-8761
700 KATLIAN ST, SUITE E
SITKA, AK 99835

PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Sitka Medical Center to serve the health care needs for you and your family. We are pleased to participate in your health care and look forward to establishing a lasting relationship as your health care provider. As part of this relationship, we have outlined our expectations for your financial responsibility in our Patient Financial Responsibility Policy. Please read this document thoroughly.

Address Change

☒ It is important that we have your correct address information on file. Please advise us when there is any change to your address, telephone or other contact information.

Co-payments, Deductibles and Co-Insurance

☒ Co-payments are collected at the time of check-in.

☒ Insurance deductibles and fees for services not covered by your insurance policy, if known, are due at the time the service is rendered. We accept cash, check and most major credit cards.

Billing

☒ If you owe additional money after your visit, you can expect to receive a statement. Statements are mailed out on a monthly basis. Payment is due upon receipt of your statement.

Prompt Payment

☒ Just as we make every effort to accommodate you when you are in need to medical care, we expect that you will make every effort to pay your bill promptly. Payment is due at the time services are provided or upon receipt of a statement from our billing office..

Failure to Pay and Non-Emergency Appointments

☒ Patients who ignore collection notices and fail to pay their balance will only be seen on an emergency basis.

☒ Past Due accounts may hinder your ability to have non-emergent appointments scheduled.

☒ Should your account balance become uncollectible or if you file bankruptcy, we will continue to see you on an emergency basis only for 30 days, giving you time to find a new source of medical care.

☒ Outstanding balances or failure to pay co-payments upon check-in may result in physicals and other routine or screening appointments being rescheduled

Fees

☒ Returned checks are subject to a $25 fee and your account will be placed on a “cash-only basis.” We will accept payments only by cash or credit card until the balance is cleared.

☒ Failure to give 24 hours cancellation notice or failure to keep your scheduled appointment may result in a charge of $50. Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a fee for canceled or missed appointments. If you must cancel an appointment, Sitka Medical Center requires a minimum of 24 hours’ notice.

☒ There is an administrative fee for completing forms such as DMV, physical forms, FMLA, leave of absence, disability etc. Most forms require 5 to 7 working days to research your information and complete the form.

☒ There may be additional charges applied to your account if we are asked multiple times to copy medical records per patient request or participate in a Deposition or Phone Consultation on your behalf.

Self-Pay Patients

☒ Self-pay patients should be prepared to pay at the time of each visit.

Guarantor

☒ Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. If another party is responsible for payment of your account, you must pay your

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balance in full and negotiate repayment with them outside of our office. This policy includes individuals negotiating divorce agreements.

Minors and Dependents

☒ Parent and guardians are responsible for payments for their dependents at the time services are rendered. Minors and dependents must present a valid insurance card at each visit if a claim is to be filed. It is your responsibility to work out the payment of your child's medical care between the custodial and noncustodial parent.

Insurance

☒ ***It is important for you to be an informed consumer, who understands the specifications of your insurance policy.*** Your health insurance policy is a contract between you and your Health Insurance Company or employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether or not our physicians participate.

☒ As a courtesy to you, we will bill your insurance company directly for medical services rendered. If problems arise regarding coverage issues, we will attempt to work with your insurance company to help resolve them prior to making it your responsibility. However, please be advised that you are nevertheless ultimately financially responsible for payment of medical services rendered.

☒ If you do not present a current insurance card, you will be responsible for payment at the time of your visit. You will receive reimbursement from Sitka Medical Center if your insurance pays the claim at a later date.

☒ You have a responsibility to provide information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 90 days, the balance will be transferred to your account and you will be responsible for payment. If we receive payment at a later date, you will be reimbursed.

☒ If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket fees and coverage limits.

☒ Sitka Medical Center contracts with many insurance plans. Before your appointment, please be sure your doctor is in-network and the services are covered under your plan.

☒ If we contact your insurance carrier regarding benefits or authorization on your behalf, we are not responsible for inaccurate information provided to us by your carrier. The information about your plan that we relay to you is in good faith.

Medicare Patients

☒ Medicare may not cover some of the services that your doctor recommends. You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.

Worker's Compensation

☒ The patient must provide at time of service: name of the carrier, the date of injury and employer at time of injury Without this information, the patient will be held responsible for all charges, and payment will be collected at time of service.

I have read and agree to the policy as outlined above.

_____
Printed name of Patient

_____ _____
Signature of Patient or Legal Guardian Date