Western Carteret Medical Center
718 Cedar Point Blvd, Cedar Point NC 28584
(p) 252-393-6543 (f) 252-393-6545

No-Show Policy

It is the policy of Western Carteret Medical Center to monitor and manage appointment no-shows. Any patient who fails to arrive for a scheduled appointment, cancels an appointment **less than 24 hours prior** to appointment, or leaves prior to being seen by a provider is considered a no-show. A patient who is a no-show more than three times in one year may be dismissed from the practice.

Procedures

- A patient is notified of the no-show policy at the time of initial registration. The no-show policy is provided in writing upon the patient's arrival.
- A patient's appointment status is manually updated by marking "no-show" when patient cancels an appointment within 24 hours prior to the scheduled appointment.
- "No-show" is noted in the patient's chart and the provider determines the following:

  No Follow-Up Necessary
  Follow-Up Urgent - Locate patient immediately
  Follow-Up necessary - contact patient and schedule visit in __days

- If this is a patient's first missed appointment, the Practice will attempt to call the patient. If the patient cannot be reached, a letter will be mailed to the patient.
- If this is a patient's second missed appointment, the Practice will mail a letter to patient.
- If this is a patient's third missed appointment, the patient may be dismissed from the practice.

□ I have read and understand the NO-Show Policy of Western Carteret Medical Center.

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Financial Policy

It is the practice of WCMC to have a financial policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care in a comfortable, personal and cost effective manner.

Payment is expected at the time of service- Payments made at WCMC amy be made by cash, check, or credit. All co-pays, co-insurances, deductibles uninsured payments, self-pay and any current statement balances are due at the time of service. Occasionally, charges may be added or modified based on the provider's assessment and treatment provided.

Patients with balances- If you have a balance on your account, you will be required to pay the balance when making a new appointment or at check-in. If you need a statement printed or explanation of charges, we will be happy to accommodate your request. All balances must be paid prior to being evaluated by Western Carteret Medical Center.

Self Pay- Patients with no insurance are expected to pay a fee of $100 for established patients or fee of $160 for new patients at the time of service, this does not include any additional procedures tht may be necessry at the time of the visit. .

Insurance Billing- Insurance claims are filed as a courtesy to our patients. If there is uncertainty during the insurance verification process, you may be charged up to $30 towards your co-insurance or co-pay. We expect payment in full within 60 days for services billed to insurance. It is your responsibility to pay any balance older than 60 days and to follow up with your insurance company for reimbursement. If we receive a payment from your insurance company after your balance has been paid, we will issue you a refund. It is your responsibility to contact your insurance company if a claim is denied, paid at a lower rate than you expected or if it has not been paid within 60 days. If we have made an error, we will gladly resubmit a corrected claim.

Third Party Litigation- Our office will not become involved in disputes arising from Third Party Claims (i.e., automobile accidents, liability claims, or Worker's Compensation).

Payment Plans- Patients who are financially able are expected to pay for medical services. Special consideration will be made to patients who are financially unable to pay for medical services. Budget and payment plans are available for accounts based on individual needs.

Adequate information will be obtained on each new patient so that the account can be processed properly. Details of when and how the fees for services are to be paid will be on an individual basis. Itemized bills are available per patient/guarantor request.

Credit Balances/Refunds- Patient refunds will not be processed until all active or past due accounts are paid in full. Refunds less than $15.00 will not be automatically refunded unless specifically requested by the patient/guarantor or insurance company.

□ I have read and understand that Financial Policy of Western Carteret Medical Center.

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Financial Agreement

- I have read the policies above and understand them.
- I agree to promptly pay all fees and charges for treatments provided to me and/or my family.
- All insurance payments for services rendered are assigned to this office.
- I understand that it is my responsibility to contact my insurance company should a claim be denied or not paid in full.
- I promise that I will pay all charges in full within 60 days after receipt of insurance payment.
- I understand that charges may occasionally be added or modified based on the provider's assessment and treatment provided.
- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance.
- I authorize this clinic to release to my insurance carrier any medical information needed to obtain payment for services rendered.
- I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date.
- If my outstanding balance has to be referred to a collection agency or attorney for collection, I agree to pay all reasonable collection costs including late charges, interest, court costs and/or attorneys fees.
- I authorize WCMC and it's agents, the use of any telephone number including wireless numbers, provided to them or published, to message or contact me regarding my accounts.

****NOTICE****

Do not sign this agreement before you read and agree to the conditions set forth above. You may request a copy of this agreement for your records.

□ I have read and understand the Financial Agreement of Western Carteret Medical Center.

□ I understand that if the patient is a minor, I accept financial responsibility for patient account.

Name/ parent or guardian of minor Date