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Patient Financial Policy

Thank you for choosing Ospina Medical as your health care provider. We are committed to building a long-term physician-patient relationship with you and addressing all your healthcare needs. We feel that having a transparent financial policy that is clear and concise is necessary to maintain our professional relationship. If you ever have any questions about our fees, our policies, or your financial responsibilities please call our office at 212-715-0888 or email us at info@ospinamedical.com.

PAYMENT is expected at the time of your visit. We will accept cash, check, credit card or debit card. Payment will include any unmet deductibles, co-insurance, co-payment, or non-covered services. If you do not carry insurance or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit.

CREDIT CARD. We require all patients to leave a credit card on file to ensure proper payment for all provided services. Credit cards will be charged for appointment no-shows and cancellations made less than 24 hours prior to your appointment. Credit cards on file can be used for co-payment, co-insurance, deductibles, out of pocket expenses, and cancellation/no show fees.

In the event of a cancellation less than 24 hours of your appointment time or a no-show for your scheduled appointment, your credit card will be charged an $80 inconvenience fee. Late cancellations or no-shows for a procedure will incur an inconvenience fee of $160. We do understand that emergencies arise, so if you are unable to make your appointment, please call our front desk at 212-715-0888 as soon as possible to avoid incurring this fee.

INSURANCE. Our providers are participating with several insurance plans and a list of accepted insurances are available upon request. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility to pay a partial or complete portion of the bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with our practice, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If you are insured by a plan with which we have no prior arrangement, we will prepare and send in claims on an unassigned basis. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us in a timely fashion. If we later receive payment from your insurer, we will refund any overpayment back to you.

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Due to the many different insurance plans available, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. You will be responsible for payment if your claim is rejected.

Not all insurance plans cover the same services. In the event your insurance plan determines a service to be not covered, you will be responsible for the complete charge. Payment is due upon receipt of an invoice from our office.

REFERRALS AND PRE-AUTHORIZATIONS. Certain health insurances (HMO,POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it prior to your visit. We will try our best to ensure that a referral is/is not necessary prior to your appointment, however please check with your insurance carrier as well prior to making your appointment. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if authorization is not obtained.

LATE CHARGES of 12% annually will be applied to all patient balances 90 days and older.

RETURNED CHECKS will incur a $30 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from the staff or physician. All bad checks written to this office are subject to collections and will be prosecuted in New York County. You may be placed on a cash only basis following any returned check.

ACCOUNTING PRINCIPLES. Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

FORM FEES. Completing insurance forms, copying medical records, etc. requires office staff time and takes away from in office patient care. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication.

Postage is additional and payment is required in advance. Copying fees for Medical Records is $0.50 per page. Ospina Medical will have 15 business days in which to copy records before making them available for patient pick up, and these 15 days will commence after payment for copying has been received and after patient has signed this form authorizing record's release.

BILLING OFFICE. If you have questions in regard to any of your billing statements, call our billing department at (855) 255-1036. Calls are taken between 8:00am and 8:00pm EST.

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CANCELLATIONS OR MISSED APPOINTMENTS. If you do not cancel your appointment at least 24 hours in advance or if you are a no-show for your appointment, we will charge an $80.00 fee. Procedure no shows and late cancellations will incur a $160 fee.

All regenerative medicine procedures require a non-refundable deposit. If you cancel your regenerative medicine procedure or are a no-show your deposit will kept. If you need to cancel and reschedule your regenerative medicine procedure, we require at least 2 weeks' notice. Any patient who reschedules their regenerative medicine procedure less than 2 weeks' notice will be subject to another deposit.

ASSIGNMENT OF INSURANCE BENEFITS. I hereby assign, transfer, and set over directly to Ospina Medical sufficient monies and/or benefits for basic and major medical care, to which I may be entitled, to cover the costs of the care and treatment rendered to myself or my dependent. I authorize Ospina Medical to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payment under my policy. I direct the insurance company or health plan administrator to release such information to Ospina Medical. I authorize Ospina Medical to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

RELEASE OF INFORMATION. I hereby authorize and direct Ospina Medical to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care all information needed to substantiate claims and payment.

COLLECTION FEES. I understand that in the event that my account is placed in collection status, any additional fees incurred due to this will be added to my outstanding balance. This includes, but is not limited to late fees, collection agency fees, court costs, interest, and fines. I understand that these additional fees will be my personal responsibility to pay in full.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature _____ Date _____

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

Ospina Medical, PLLC reserves the right to change and/or modify the information on this form at any time.