James Miller, M.D.

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Statement of Financial Policy

Please complete and mail or take this form to the office at the time of your first visit.

I, _____, agree to the financial policy of Monarch Obstetrics and Gynecology LLC

Signature of Responsible Party **Date:_____**

Thank you for choosing Monarch Obstetrics and Gynecology LLC as a healthcare partner for your obstetrics & gynecologic needs. We know you have many options and are honored you have picked us to share in your healthcare. We are committed to a successful outcome for your care plan. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. We realize healthcare expenses can be overwhelming and we want to be sure you understand your financial responsibilities. We make every effort to provide high quality care in a cost-effective manner. To keep billing costs down we ask that you pay your copays at the time of service. Also, we expect payment in full when you receive a billing statement from us. Please call our billing office at 1-866-293-4229 to discuss your bill with our friendly account representatives if you are unable to pay your account in full.

Regarding Insurance

After payment of your co-pay/co-insurance, we will gladly bill your insurance company for services provided by Monarch Obstetrics and Gynecology LLC. We participate with a large number of insurance plans (see list below) However, it is your responsibility to check with your insurance company to be sure that we are on the list of in-network providers for your specific plan. If you choose to come to our practice and we are not on your insurance company's panel, you will be responsible for the difference between what the insurance company pays and our charges. Your insurance company has the current list of participating physicians.

There is a charge for problems evaluated during an annual exam. You may be responsible for two co-payments for that date of service. You may also be required to pay a deposit on a scheduled surgery at your pre-op appointment. Our administrative department will verify insurance benefits and determine the deposit based on your deductible and coinsurance amounts.

Your insurance policy is a contract between you and your insurance company. Please be aware that some of the services provided may be non-covered services under the Medicare Program and/or other medical insurance. You will receive a statement each month even though an insurance claim is pending.

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It is the responsibility of Medicaid patients to be sure their profile with Ohio Department of Medicaid, or MCOs, such as
Buckeye, Care source, Molina or Paramount. Only the patient can add or remove other coverage and if this information is not current, Medicaid will deny your claims, making them your responsibility. Please do not ignore any statements from our billing office that state you must contact Medicaid or your case worker.

Women under the age of 26 may be covered under a parent's policy, even if they do not live with that parent. Please be sure you provide all insurance ID cards, including those of a parent. We also need to know the subscriber's date of birth.

FULL PAYMENT OF CO-PAYS AND CO-INSURANCE ARE DUE AT THE TIME OF SERVICES. WE ACCEPT CASH, CHECK, AND CREDIT CARD.

We accept Mastercard, VISA, Discovery and American Express.

Forms Completion

We charge a fee of $25.00 for all forms that require completion. You will be charged for forms such as short term and temporary disability. Your insurance does not pay the office to complete these forms. We expect this fee to be paid prior to the form being completed.

Copying fee for Medical Records

In accordance with Ohio Revised Code 3701.742, the following criteria sets our fees for requested copies.

Requests made by the patient, or guardian, for records will be follow the fee schedule below;

$3.51 per page for the first 10 pages $.73 per page for pages 11-50 $.29 for pages 51 and higher

Requests made by a person or organization other than the patient, for records will be follow the fee schedule below;

$21.00 search fee $1.42 per page for the first 10 pages $.73 per page for pages 11-50 $.29 for pages 51 and higher

There may also be separate fee for retrieving images and postage incurred.

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Returned Check Fee

We charge a fee of $50.00 for all checks returned for non-sufficient funds

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our specialty. You are responsible for payment regardless of your insurance company's determination of usual and customary rates.

Minor Patients

The adult accompanying a minor, the parents (or guardian of the minor), are responsible for supplying insurance information. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at the time of service.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments. The fee for a missed appointment is $25.00. This cannot be billed to your insurance and is your personal responsibility. This amount must be paid prior to scheduling another appointment. This fee will be charged to Medicaid patient, allowable due to this advanced notice.

Facility Lab & Image Charges

You may get a separate bill from the facility that performs your lab work or images, such as X-rays, MRI, CT scans. These charges should be discussed directly with the facility that is providing those services. We may perform limited lab testing in the office. Any testing done in the office will be charged by Monarch Obstetrics and Gynecology only.

Self-Pay Patients

All patients are expected to pay for services at the time that they are received. However, some medical procedures are expensive and unexpected, and as such, may require time for payment. Payment over time is not permitted unless specifically authorized by a member of the business office staff. Self-pay patients who have no balance on their account will be given a same-day discount for all payments made the date of service. Patients failing to pay at the time of service will not be eligible for prompt payment discounts.

Bankruptcy

If this office has been included in your bankruptcy, you will no longer be a patient with the practice.

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Termination

We use a collection agency for all accounts that we are unsuccessful in collecting. In that event, you will be sent a letter terminating our services to you and/or your family from this office. You will be given a 20-day period of time to establish yourself with a new doctor. During those 30 days, you can be seen by the doctor for emergencies only.

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

My signature above verifies that I understand that the responsibility for payment for Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a rebilling fee will be added to any balance over 30 days. I understand and agree to this Financial Policy

Obstetric Self-pay Packages

Our business office will discuss a bundled package with Wooster Community Hospital.

Surgical Self-pay Packages

Our business office will discuss a bundled package with Wooster Community Hospital.

Thank you for the trust you have placed in us. We want you to know, we're here for you.

IN-NETWORK INSURANCE PLANS

Medicare
Ohio Department of Medicaid, including Buckeye, Caresource, Molina and Paramount
Anthem BC/BS
Medical Mutual of Ohio
Summa
Aultcare/Prime Time
Humana
Cigna
United Healthcare

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SURPRISE BILLING ACT

The No Surprises Act protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out- of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. It also establishes an independent dispute resolution process for payment disputes between plans and providers and provides new dispute resolution opportunities for uninsured and self-pay individuals when they receive a medical bill that is substantially greater than the good faith estimate they get from the provider.

Starting in 2022, there are new protections that prevent surprise medical bills. If you have private health insurance, these new protections ban the most common types of surprise bills. If you're uninsured or you decide not to use your health insurance for a service, under these protections, you can often get a good faith estimate of the cost of your care up front, before your visit. If you disagree with your bill, you may be able to dispute the charges. Here's what you need to know about your new rights.

WHAT ARE SURPRISE MEDICAL BILLS?

- Before the No Surprises Act, if you had health insurance and received care from an out-of-network provider or an out-of-network facility, even unknowingly, your health plan may not have covered the entire out-of-network This could have left you with higher costs than if you got care from an in-network provider or facility. In addition to any out-of-network cost sharing you might have owed, the out-of-network provider or facility could bill you for the difference between the billed charge and the amount your health plan paid, unless banned by state law. This is called "balance billing." An unexpected balance bill from an out-of-network provider is also called a surprise medical bill. People with Medicare and Medicaid already enjoy these protections and are not at risk for surprise billing.

WHAT ARE THE NEW PROTECTIONS IF I HAVE HEALTH INSURANCE?

If you get health coverage through your employer, a Health Insurance Marketplace®, 1 or an individual health insurance plan you purchase directly from an insurance company, these new rules will:

- Ban surprise bills for most emergency services, even if you get them out-of-network and without approval beforehand (prior authorization).
- Ban out-of-network cost-sharing (like out-of-network coinsurance or copayments) for most emergency and some non-emergency You can't be charged more than in-network cost- sharing for these services.
- Ban out-of-network charges and balance bills for certain additional services (like anesthesiology or radiology) furnished by out-of-network providers as part of a patient's visit to an in-network

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- Require that health care providers and facilities give you an easy-to-understand notice explaining the applicable billing protections, who to contact if you have concerns that a provider or facility has violated the protections, and that patient consent is required to waive billing protections (i.e., you must receive notice of and consent to being balance billed by an out-of-network provider).

1 Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

WHAT IF I DON'T HAVE HEALTH INSURANCE OR CHOOSE TO PAY FOR CARE ON MY OWN WITHOUT USING MY HEALTH INSURANCE (ALSO KNOWN AS "SELF-PAYING")?

If you don't have insurance or your self-pay for care, in most cases, these new rules make sure you can get a good faith estimate of how much your care will cost before you receive it.

WHAT IF I'M CHARGED MORE THAN MY GOOD FAITH ESTIMATE?

For services provided in 2022, you can dispute a medical bill if your final charges are at least $400 higher than your good faith estimate and you file your dispute claim within 120 days of the date on your bill.

WHAT IF I DO NOT HAVE INSURANCE FROM AN EMPLOYER, A MARKETPLACE, OR AN INDIVIDUAL PLAN? DO THESE NEW PROTECTIONS APPLY TO ME?

Some health insurance coverage programs already have protections against surprise medical bills. If you have coverage through Medicare, Medicaid, or TRICARE, or receive care through the Indian Health Services or Veterans Health Administration, you don't need to worry because you're already protected against surprise medical bills from providers and facilities that participate in these programs.

WHAT IF MY STATE HAS A SURPRISE BILLING LAW?

The No Surprises Act supplements state surprise billing law; it does not supplant them. The No Surprises Act instead creates a "floor" for consumer protections against surprise bills from out-of-network providers and related higher cost-sharing responsibility for patients. So as a general matter, as long as a state's surprise billing law provides at least the same level of consumer protections against surprise bills and higher cost-sharing as does the No Surprises Act and its implementing regulations, the state law generally will apply. For example, if your state operates its own patient-provider dispute resolution process that determines appropriate payment rates for self-pay consumers and Health and Human Services (HHS) has determined that the state's process meets or exceeds the minimum requirements under the federal patient-provider dispute resolution process, then HHS will defer to the state process and would not accept such disputes into the Federal process.

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As another example, if your state has an All-Payer Model Agreement or another state law that determines payment amounts to out-of-network providers and facilities for a service, the All-Payer Model Agreement or other state law will generally determine your cost-sharing amount and the out-of-network payment rate.

WHERE CAN I LEARN MORE?

Still have questions? Visit **CMS.gov/nosurprises**, or call the Help Desk at 1-800-985-3059 for more information. TTY users can call 1-800-985-3059.