State of Franklin Healthcare Associates

State of Franklin Healthcare Associates, PLLC
Registration, Billing and Collection

Payment Policy

We are participating with Medicare, Tennessee Medicaid, and most Managed Care plans in the area. We will file these claims for you. Patients are expected to pay any deductibles, coinsurance or copay amounts owed at the time of service.

If you are a Medicare patient and do not have a supplemental plan or a Medicare Advantage plan, you are responsible for payment of the annual deductible, co-insurance and non-covered services at the time of service.

Patients with a third party coverage with whom we do not contract are responsible for payment in full at the time of service. As a courtesy, we will file your charges with this third party payer upon receipt of payment in full. Otherwise, we will provide you with a completed third party payer claim form to use in filing your insurance.

Patients with a High Deductible Health Plan that have not met their annual deductible amount on the date of service will be asked to pay $50.00 at the time of service for primary care providers and a percent of the charge amount for specialists. You will be billed for any additional deductible amounts after the insurance processes the claim.

Patients without verifiable insurance will be responsible for payment of all services rendered at the time of service. We accept cash, check, Visa, MasterCard, Discover and American Express.

Please realize, however, that:

1. Your insurance is a contract between you and your insurance company. We are not a party to that contract.

2. Depending on the specifics of the agreement we have with your insurance company, any portion of our fees not covered may be the responsibility of the patient.

3. Not all services are a covered benefit in all counts. Some insurance companies arbitrarily select certain services they will not cover. Any service not covered is the responsibility of the patient.

Regardless of insurance payment the patient and/or guardian remains responsible for all financial obligations incurred at the time of service. We realize that some balances may not be able to be paid in full at time of service and we will be happy to assist you in making satisfactory payment arrangements.

By signing this financial policy acknowledgement of the financial responsibility is accepted. This will remain in effect until revoked in writing.

______________________________	______________________
Patient Name	Patient Date of Birth
______________________________	______________________
Patient or Guardian Signature	Date