Patient Financial Policy

1560 Turf Lane, East Lansing, MI 48823
1100 South Cedar Street, Mason, MI 48854
517-484-3000 Phone
517-484-6358 Fax

Dear Patient:

The purpose of this document is to help you understand your responsibilities regarding your insurance, eligibility, coverage and payment responsibilities.

Alliance renders medical services based on evidenced based medical guidelines and not insurance benefits. As such, not all insurance companies/third party payers will pay for all services. Each policy has its own benefit rules regarding covered services or amounts of coverage. Because this is true you are responsible for knowing and understanding your own insurance policy, eligibility and coverage. To check your benefits, call the number on the back of your insurance card.

All insurance companies state that verification of coverage is not a guarantee of payment. Actual benefits are determined by your insurance company after a claim is received.

Your Financial Responsibility:

- Co-pays are due prior to service. If an outstanding amount is owed it must be paid prior to the next scheduled appointment. Any balances left unpaid will be subject to interest charges.
- Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred.
- Changes in insurance must be reported to our billing staff immediately by calling 517-484-3000 option 5.
- There is a $75.00 charge for any appointment missed or cancelled less than 24 hours in advance.
- There is a charge of $35.00 for all checks returned for insufficient funds.
- Your account will be turned over to a collection agency for collection if it is deemed the account is in default or in noncompliance with this policy. A 25% administrative fee may apply.
- I understand that Alliance may not participate with my insurance. If I choose to have my care at Alliance I will have to file a claim for services with my insurance company and that I will be required to pay for my services on the date that I receive them.

By signing this document, the patient or patient's representative authorizes Alliance Obstetrics & Gynecology and/or collection service providers to use all information provided by the patient or representative for contact.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Witness Date