



## **Financial Policy**

### **Insurance Verification**

At each visit, the patient must provide an active insurance card with current, correct information. Without proof of insurance, the patient may be re-scheduled. Galen Medical Group makes it a priority to verify proof of a patient's insurance; however, it is the patient's responsibility to know his/her benefits **including wellness benefits** prior to time of service.

### **Patient Cost Co-Pays & Co-Insurance**

Insurance companies require Galen Medical Group to collect co-pays, deductibles or co-insurance amounts at the time of service. A deposit equal to 1/3 of costly procedures or visits is required in advance for services not covered by the patient's insurance.

A \$12.00 processing fee will be added for co-pays that are not paid at the time of service.

### **Outstanding Balances**

Patients will be asked to settle any outstanding balances with Galen Medical Group before their appointment. As a patient, you may pay any outstanding balances at any of our Galen Medical Group facilities.

Patients with outstanding balances may be declined treatment or triaged for non-emergency care until the balance is resolved.

Patient balances which are not resolved in a timely manner will be sent to an outside collection agency. If the patient's balance is transferred to an outside agency, the patient will be responsible for paying any additional collection fees associated with the collection of the patient balance.

### **Self-Pay**

Galen Medical Group recognizes that not everyone has insurance coverage. It is difficult to accurately predict what services a patient may ultimately need, but Galen will try to work with the patients to help them anticipate charges and manage their healthcare expenses.

Patients without insurance who pay in full at the time of service may be eligible for a discount.

For patients without insurance or the resources to pay for care, Galen supports the Volunteers In Medicine Clinic, a free primary care clinic located at 5705 Marlin Road in Chattanooga. Residents of Hamilton County who qualify can receive free care from Galen Medical Group physicians and other physicians who volunteer at the clinic.

**Billing Insurance**

Galen Medical Group contracts with most insurance companies for patient services. The patient remains financially responsible for all his or her care, but the remaining balance for services rendered to the patient will not be billed to the patient until payment is received from the insurance company(s), the insurance company denies the claim, or the insurance company unreasonably fails to pay in a timely manner. A statement will be sent to the patient or responsible party. The billed amount on the statement is due when the first statement is received. If payment is not received within 30 days, 10% interest will be applied to the outstanding balance until the account is paid in full.

**No-show and Late cancellation Fee**

Patients who cancel appointments with less than 24 hours notice or do not come to scheduled appointments may be subject to a \$25.00 fee, not for any service, but for the lost opportunity to see another patient. Patients who cancel appointments with less than 72 hour’s notice may be subject to a \$200 fee for procedures.

**Payments**

Galen Medical Group accepts cash, check, Visa, MasterCard or Discover. There is a \$30.00 fee for all returned checks.

**Payment can be sent to:**

Galen Medical Group  
P.O. Box 1030  
Chattanooga, TN 37401

**To bring payment in person:**

Eastgate Mall  
5600 Brainerd Rd. Suite H-100  
Chattanooga, TN 37411

**To Pay Online:**

[www.galenmedical.com](http://www.galenmedical.com)

If you have any questions regarding our financial policies, please contact our Patient Business Services Representative at **(423) 894-3725**.

**NOTE:**

Patient Accounts with outstanding balances and no payment activity will be forwarded to a collection agency at the patient’s expense. In addition to any outstanding balances, the Patient or the Patient's representative who signs below agrees to pay interest on the balance at 10%, plus all costs associated with such collection activity, including reasonable collection agency fees, attorney fees, and court costs.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Patient Name