

## UNDERSTANDING YOUR FINANCIAL RESPONSIBILITIES

At the Ear Medical Group, we are committed to educating our patients and their families about financial responsibilities related to services. We realize that there is an overwhelming amount of information that is given to you during your office visit concerning your disease, diagnosis, and treatment. Much of the information is technical and difficult to understand. When the financial and insurance terminology is added on top of this, the result can easily be total confusion. The following is a list of definitions and explanations that we hope you will find helpful in understanding your insurance statements and billing obligations.

At the Ear Medical Group, we provide state of the art, world-class medical care. Unfortunately, sometimes this places us in the difficult position of recommending a treatment that is not currently covered by insurance. Nevertheless, at the Ear Medical Group, we must act first and foremost as the patient's advocate in regards to their healthcare needs. This will occasionally mean that you as an insured patient will have a greater out of pocket expense than you may have anticipated.

Documentation regarding your history and symptoms has become a very important part of the reimbursement process. In order for us to obtain proper and fair payment from the insurance companies, we are required to document a tremendous amount of information with each visit. As a consequence of this, it will be necessary for you to fill out several forms before and during your visit at the Ear Medical Group. We apologize for this inconvenience, but your patience and thoroughness in filling out any forms is critical to our process and greatly appreciated.

After reading this information, if you have any questions, please feel free to call our reimbursement department. The reimbursement department is open Monday through Friday from 8:00 a.m. to 5:00 p.m. Financial counseling is available to all our patients via an appointment or by telephone consultation at (210) 614-6070. Thank you again for choosing the Ear Medical Group. Page 2

### HELPFUL DEFINITIONS:

**Copayment** – An amount of money that is required by the insurance company to be paid by the patient to the Ear Medical Group at the time the services are rendered. Your insurance company determines how much this amount will be. The amount should be listed on your insurance card. Medicare does not have copays, but commercial plans typically do. Medicare refers to the patient's portion as co-insurance.

**Deductible** – The part of an annual insurance healthcare expense that the patient must pay out of pocket before any insurance coverage applies. This amount varies according to the guidelines set by each insurance plan.

**Guarantor** – The person who assumes responsibility for payment of the bill.

**HMO (Health Maintenance Organization)** – An HMO is a prepaid health plan in which providers are paid a fixed amount to treat patients covered under the plan. HMOs typically contract with specific groups of doctors (panels) who can meet the criteria that is set by the company for care. Persons who have an HMO type insurance **must** choose a **PCP** (primary care physician) who will manage all of your healthcare needs and **must** approve any type of care the patient receives. In other words, patients must first see or contact their primary care provider to get approval, or a referral, to go to see a specialist, or go to a hospital or an emergency room for care. Typically, with an HMO, there is an established copay and the patient only pays this amount for each doctor visit or hospital visit. The HMO picks up the remainder of the cost for healthcare services.

**PCP (Primary Care Physician)** – A physician who is considered a general practitioner (meaning they provide care for the “whole person” instead of specializing in one particular part or system of the body).

**PPO (Preferred Provider Organization)** – A group of physicians or hospitals who contract with an employer to provide healthcare services to their employees at a discounted fee. In a PPO, the patient may go the physician of his or her choice, even if that physician does not participate in the PPO plan, but the patient will have to pay a higher percentage of the cost for the services when they go out of network.

**Precertification or Prior Authorization** – A process of evaluation by a health plan or provider to determine if a specific medical service will be covered by the insurer. This is a requirement for all patients participating in an HMO or PPO.

**Primary Insurance** – This is the patient’s main source of medical coverage and is always billed first for services rendered.

**Provider** – Any person/organization who provides healthcare to consumers, including physicians, hospitals, pharmacies, and home care agencies.

**Secondary Insurance** – This is a supplemental or additional type of insurance that a patient may carry in addition to the primary or main policy. The secondary insurance is billed after payment is received from the primary insurance. Depending on the plan and the services covered, the secondary insurance should cover medical expenses not paid by the primary insurance company on covered benefits.

**Specialist** – The physicians, audiologists, and physical therapists of the Ear Medical Group. Our practice is limited to diseases of hearing and balance, facial nerve, and skull base tumors and diseases.

**Subscriber** – The person who is the policyholder for the insurance coverage.

## QUESTIONS and ANSWERS

### **“If I have insurance, why do I still receive a bill?”**

The most important thing to remember when preparing for any healthcare visit is to be familiar with the terms of your insurance and to be sure that you understand the rules and regulations which you must follow to access care. If you do not follow the rules of your insurance plan, you may be denied approval for the services you wish to receive and the full financial burden of coverage may fall upon you, the patient. Remember, if you are part of an HMO, there will **always** be a copayment due at the time of service and you must **always** contact your assigned primary care physician **PRIOR** to seeking service or showing up for an appointment. As the patient, **you are responsible for obtaining precertification or prior authorization from your primary care physician and you must bring this with you to the office.** This will ensure that most or your entire bill will be paid. There may, however, be charges billed to you that your insurance will not cover. If this is the case, then you as the patient are responsible for payment of these services. The best advice to follow is to contact your insurance carrier for educational assistance if you have questions.

### **“What is the billing process?”**

Once you finish your office visit at the Ear Medical Group, a series of steps occur which make up the billing process. These steps vary depending on the type of insurance coverage you have. The following is provided as an example to explain the process to you in a simple picture.

#### A. Uninsured patients

1. A detailed invoice will be provided to you at the checkout period at the time of the office visit.
2. Full payment is expected at the time of the visit.
3. If you would like to make special payment arrangements or have charity consideration, this could be done by calling our reimbursement department at (210) 614-6070 or by an appointment at the business office.
4. For charity consideration, all patients must discuss this in advance with their physician at the Ear Medical Group.
5. If no payment is made and/or arrangements for a payment plan have not been adhered to, we begin a collection process.

#### B. Insured patients

1. At the time of the outpatient visit, an invoice is prepared and given to the patient with his/her financial obligations (copays or deductible) stated. This information is provided to us by your insurance company.
2. We file a claim for reimbursement with your insurance company (primary, then secondary). We work diligently with insurance companies to provide the information necessary to process the claim for payment. The information you give us must be accurate.

3. Services not covered by the insurance company are considered patient responsibility. Patient charges should be paid in full or payment arrangements made through the reimbursement department at (210) 614-6070. Payment of a balance resulting from patient portion or noncovered charges is expected within 30 days.
4. If no payment is made and/or arrangements for the payment plan have not been attempted or adhered to, the collection process is followed.

**“Will I be responsible for charges if I have Workman’s Compensation coverage?”**

Occasionally, patients come to the Ear Medical Group seeking care as a result of an on the job injury. In these situations, if you have followed appropriate procedures from your workplace, your injury should be on file and your Workman’s Compensation insurance carrier should have been notified. All Workman’s Compensation treatment requires **ADVANCED NOTIFICATION** and **AUTHORIZATION** from your carrier. In other words, they must approve any type of medical care you plan to receive in advance. At the time of your visit, we will ask you for copies of your paperwork from your Workman’s Compensation carrier. This paper will have the authorization numbers and documentation that we need for billing purposes. If you forget your paperwork, you will be personally responsible for all services rendered or we will need to reschedule the appointment. You may bring this in person to our reimbursement department or have it faxed to (210) 615-6814.

**“What is a notice of noncoverage?”**

Once your physician determines that you need a particular test or treatment, we will request approval by your insurance plan. If your insurance plan does not consider the test/treatment a covered benefit, we will present you with a notice of noncoverage. You will be asked to sign stating that you understand the recommendation for testing/treatment, agree and accept responsibility for payment of the service. If you have any questions about this, you may call our reimbursement department at (210) 614-6070.