66840 Belmont Morristown Rd • Belmont, OH 43718
Phone 740-782-1031 • Fax 740-782-1180

Office Hours:

Shaun Roe, DO
Monday & Thursday 8:00am – 4:00pm
Tuesday 8:00am – 6:30pm
Wednesday 8:00am – 12:00pm
Friday 8:00am – 3:00pm

Stacey Meeks, DO
Carissa Allen, PA
Monday, Wednesday, Thursday 8:00am – 4:00pm
Tuesday 8:00am – 6:30pm
Friday 8:00am – 12:00pm

**AFTER HOURS: If you wish to cancel an appointment, or have our office staff return a call, please leave a voicemail on our main line. We will return your call the next business day. The provider on call can be reached by calling 1-800-874-2400. If you have a true medical emergency, please report to the nearest emergency department.

<u>Injections</u>
Monday, Tuesday and Thursday 9:30am -11am, 1:30pm – 4pm

<u>Laboratory</u>
Monday through Friday 8:00am – 11:30am, 1:30pm - 4pm

Appointments must be canceled within 24 hours. We do realize there will be emergencies where a telephone call cannot be made within 24 hours. If an emergency occurs, please call our offices as soon as possible so that we might reschedule your appointment.

Please keep this page.

Belmont Professional Associates, Inc.

Office Policy

Our goal is to provide and maintain an excellent provider-patient relationship. Advising you of our office and financial policies allow for better understanding of expectations and enables us to achieve this goal.
Please read each section carefully and initial. **If you have any questions, do not hesitate to ask a member of our staff.**

APPOINTMENTS

- Patient agrees to complete a new demographic form, annually. Patient is responsible for alerting staff when changes need to be made throughout the year.
- Belmont Professional Associates, Inc. appreciates a 24-hour notice of appointment cancellation. **There is a $25 charge for missed appointments.**
    - Three (3) no call/no shows will result in dismissal from the practice.
- If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, it may be necessary to reschedule your appointment.
- If you are here for multiple procedures, the provider will determine whether or not to perform all of these procedures during the same office visit or to schedule them at a future date. We cannot guarantee multiple procedures on the same day of service.
- If the reason for the visit is due to a MVA, Patient must notify the staff, complete an MVA form and provide all accurate and complete policy information at the time of service. If complete information is not provided, the visit will be considered self pay and will require a $100 payment at the time of service. BPA does not accept letters of protection from Law offices as payment for services rendered.
- If the reason for the visit is a CDL/DOT physical, the patient will be billed as self-pay. It is the patient's responsibility to pay for the visit and be reimbursed by employer. **Commercial insurance will not pay for this.**
- **BPA does not accept workers' compensation claims.**

Initial:______

INSURANCE

- Belmont Professional Associates, Inc. accepts most insurances and self-pay patients.
- In order to efficiently and properly bill insurance companies, BPA requires Patients to bring your insurance cards for every visit. Failure to present current insurance card may require your appointment to be rescheduled.
    - **It is the responsibility of the patient to provide *accurate* and *timely* insurance information. Inaccurate or untimely information given to the staff that results in denial or non-coverage by your insurance company will be the patient's responsibility.**
- Patients are responsible for obtaining the details of insurance coverage and are responsible for notifying BPA of any changes to coverage, any necessary prior authorizations, if written referral or authorization is required to see specialists, and what services are covered.
- Not all services provided by BPA are covered by every insurance plan. Any service determined not to be covered by your plan will be patient responsibility.
    - Patients should check with their insurance company to be sure the visit will be covered prior to scheduling an annual physical appointment or sports physical. Not all plans cover annual healthy physicals, some pay once every 365 days, and some pay every calendar year.
- Because BPA handles many different kinds of insurance, we may not have all the details of your insurance plan. Some of your questions can be best answered by a representative of your insurance company.

Initial:______

(OVER)

FINANCIAL RESPONSIBILITY/BILLING

- Patients are responsible for all co-pays and are due at the time of service. Deductibles and coinsurance are patient responsibility. Co-pays are collected at time of service, deductibles and coinsurance will be billed to patient by our office.
    - **BPA accepts cash, check, debit, or credit cards (MasterCard, Visa, Discover)**
    - **If you are experiencing financial difficulty, please let us know.** We offer payment plans and financial assistance. (You may be required to apply for Medicaid coverage if you are unable to meet the “Payment Plan”. A Medicaid denial will qualify you to be considered for “Financial Assistance”
- If a patient has no insurance, a $50 down payment for an office visit is to be paid at the time of visit.
    - We offer discounts as stated below.
    - ****Co-pays, deductibles, and co-insurance amounts are not eligible for discount due to your agreement with your insurance plan.**
    - If previous arrangements have not been made with our billing office, any account balance outstanding greater than 90 days will be forwarded to RCS collections agency. Failing to adhere to payment arrangements can result in dismissal from the practice.
- The charge for a returned check is $25. Payable by cash or money order. This will be applied to your account in addition to the insufficient fund amount and any bank fees incurred. The patient’s account status can be placed on a cash only basis following any returned check until the entire balance, including fees, are paid in full.
- Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age you are ultimately responsible for payment of the service. Our office will not bill any other personal party.
    - For all patients <18 years old, the accompanying parent or adult is responsible for full payment at the time of service.

Initial:______

SELF-PAY ACCOUNTS

- For patients that have no insurance, payment for an office visit is to be paid at the time of visit.
    - We require a $50 down payment for all self-pay visits.
    - Visits paid in full with cash or check will be offered 20% off the total.
    - Visits paid in full with debit or credit will be offered 15% off the total.
- **In cases of financial difficulty, please let a member of the BPA billing team know.** We offer payment plans and financial assistance.

Initial:______

REFERRALS

- If your insurance plan requires a referral for you or your child to see a specialist, or for procedures or laboratory tests, you must allow BPA 3-5 business days to initiate the precertification process prior to obtaining services. You may have to reschedule your appointment if enough notice is not given to prepare your referral. Only emergency referrals will be completed in the same day.
    - It is the patient’s responsibility to check participation of their selected specialist.

Initial:______

(OVER)

FORMS/RECORDS

- Family and Medical Leave Act forms are $25. Payment is due when the forms are dropped off.
- A copy of your complete record is available based on the following fees:
    - Record Search $15
    - Per page 1-10 $1
    - 11-50 $0.50
    - 51+ $0.25
    - Plus actual postage TBD
- Transfer of records to another physician is free of charge.

Initial:______

I have read and fully understand this office policy set forth by Belmont Professional Associates, Inc. and agree to comply and accept the responsibility for any payment that becomes due as outlined previously. If you have any questions please ask one of the staff members or call our billing office at (1)-740-425-5176.

Patient Name: ____

Responsible Person's Name: ____ Relationship: __________________

Responsible Person's Signature: ____ Date: _____________

Witness: _____________________________________

On completion we will provide you with a copy for your records

Patient Information Sheet Today's Date__/___/___

Patient: Last Name_______________________________First Name__________________MI______________
Mailing
Address____________________________________City______________________State_____Zip_________
Telephone#_________________________Cell#____________________________DOB__________________
Social Security#___________________Drivers License#___________________Male/Female (circle one)
Email address:____Fax number:______________________

Marital Status(circle one)	Single	Married	Separated	Divorced	Widowed

Employer_____________________________________Employer Phone#______________________________
Employer Address____________________________City_________________State_____Zip_____________

ALTERNATE CONTACT: ***LIST a name and number OTHER than the one listed above***
Name_____________________________Phone #_____________________Relationship_________________
Name_____________________________Phone #_____________________Relationship_________________

List your Primary Care Physician: Dr___________________________
List your Specialist: Dr____

Primary Insurance Company____________________________________Effective date__________________

Address____City___________________State______Zip________
Policy/ID#______________________Group#______________________Ins Phone #____________________
Subscriber Name________________________Birthdate________________SS#_________________________
Subscriber Address______________________City____________________State_______Zip______________

Relationship to patient: (Circle one) Self Spouse Parent Guardian

PAYMENT RESPONSIBILITY: List the parent/guardian or responsible person for payment.

First Name_______________________MI_________Last Name___________________________
Address ____
City_____________________________________State____________________Zip_____________
Relationship to patient ______________________________________
Social Security No.___________________DOB ___________________
Phone Number ____

Secondary Insurance Company__________________________________Effective date__________________
Address____City___________________State______Zip________
Policy/ID#______________________Group#______________________Ins Phone #____________________
Subscriber Name________________________Birthdate________________SS#_________________________
Subscriber Address______________________City____________________State_______Zip______________
Relationship to patient: (Circle one) Self Spouse Parent Guardian

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I hereby acknowledge that on _____/____/____, I received the Notice of Privacy Practice of Belmont Professional Associates, which set forth the way in which my personal health information (PHI) may be used or disclosed by Belmont Professional Associates and outlines my right with respect to such information.

____ ______________________

Patient/Parent/Guardian Signature Date

Insurance:

1. I allow the release of any information relating to my care to any appropriate insurance company for the purpose of processing an insurance claim or for any valid medical purpose.
2. I authorize the provider at BPA to prove me any medically indicated treatment.
3. I authorize my medical insurance company to pay directly to BPA any amount allowed for the medical care provided.

Please initial each paragraph: Signature on file.

_____Medicare/Medicaid: I request that payment of authorized Medicare benefits be made on my behalf to Belmont Professional Associates for any service furnished to me by a health care provider employed by BPA.

_____ Other third party payers: I hereby request an authorize the payment of any health insurance, medical plan or other benefits that cover payment for medical care or services provided to me to be paid on half to Belmont Professional Associates for services rendered.

Other:
I authorize the office to:

___ Leave a message on my answering machine ___yes ___no
___ Leave a message at my place of employment ___yes ___no
___ Discuss my medical condition with a member of my family?

___yes, Whom? ______________________________
___no

FOR OFFICE USE ONLY BELOW THIS LINE

EMPLOYEE INITIALS ___ DATE: ___/___/___

____ SIGNATURE NOT OBTAINED:
Reason: ___ Patient refused to sign.
___ Other __________________________

Description of attempts made to obtain signature:

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