PANACEA ALLERGY Security Deposit Policy

Insurance Company/Guarantor Non-Payment, Non-Response and Recoupment Security Deposit*:

Panacea Allergy is a fee-for service, private medical practice that has agreed to bill and accept payment from a patient's insurance company. Since payments from both insurance companies and guarantors are not guaranteed, we require an ongoing security deposit to cover the cost of our services until a payment is made.

We will honor all contracted discounts that apply to each insurance plan. If a "no-response" or "non-payment" or "recoupment" occurs from the patient's insurance plan on file, we will honor the discount from the last active insurance plan fee-schedule or apply a self-pay discount. We will then assign the adjusted payment responsibility to the patient. We do NOT "balance bill".

It is the patient/guarantor responsibility to keep insurance information up to date with our office and to verify their coverage before each visit.

It is the patient/guarantor responsibility to honor the "patient responsibility" portion of their bill, as assigned by their insurance company.

It is the patient/guarantor responsibility to pay our discounted bill in full if the insurance company does not respond or denies a claim by issue of a non-payment or recoupment determination.

If a no-response or non-payment or recoupment is issued, we will assist the guarantor in locating proper payor information and refile an updated claim on the patient's behalf. If appropriate, we will assist the guarantor in appealing the insurance company decision. In the interim, the guarantor will be responsible for timely payment of our discounted services. If an eventual payment is made on behalf of the patient by an insurer, the credit amount will be refunded to the guarantor, 3 months after all current adjusted charges have been paid.

Security deposit payments:

Initial and replenishment security deposit payments are processed at check-in or by phone using a personal credit card or personal check. Security deposit payments will be added to the patient balance in our practice management system and on patient statements and will show as a negative balance/credit until applied.

HSA cards cannot be used for security deposit funds. Please use a personal credit card or personal check for the security deposit.

New Patient Deposits:

1st visit- $300

2nd (procedure) visit- $300

3rd visit- $150

Old/New Patient Deposits:

1st visit-$300

Procedure visit (if needed)- $300-600 depending on estimated cost of service

Follow up visit- $150 to be replenished at each service.

Active/Existing Patient Deposits:

Initial Deposit- $150 to be replenished at each service.

Procedure Visit- $300-600 depending on estimated cost of service.

Inactive Patient Deposits:

Security deposit is not needed if payments are up to date.

Next service request- $150 at the request of any service and transfer to Active status.

Security deposit utilization:

Security deposit funds will be applied to unpaid patient responsibility in the following order:

Per patient/guarantor request at any time if payment by other means (eg. HSA) is not available.

At the next request for service, if interim claims have been processed and billed to patient responsibility, and payment by other means (eg. HSA) is not available.

After 3 months of nonpayment of patient responsibility amounts

Security deposit funds will also be applied to unpaid balances for non-response claims, non-payment claims and recoupment claims within 1-3 months of claim submission or insurance notification of such.

Ongoing replenishment is required if the expected cost of a new service, plus outstanding claims exceed the credit balance.

Security deposit refunds:

New Patient status with excess deposit on file- A partial refund will be issued upon request, if exceeds Active status deposit amount ($150), 3 months after all previously adjusted charges have been paid.

Transfer from New Patient to Active status- A partial refund will be issued upon request, if exceeds Active status deposit amount ($150), 3 months after all previously adjusted charges have been paid.

Active status with excess deposit on file- A partial refund will be issued upon request, if exceeds Active status deposit amount ($150), 3 months after all previously adjusted charges have been paid.

Transfer from Active status to Inactive status- A refund of any unused portion will be issued upon request, 3 months after all adjusted charges have been paid.

Discharged status/Transfer of care- A refund of any unused portion will be issued upon request, 3 months after all adjusted charges have been paid.

*Definitions:

Patient- Person who receives medical services.

Patient responsibility- Amount owed by the patient's guarantor, as assigned by the insurance company (deductible, co-insurance, copay) or as a discounted self-pay amount for services rendered.

Guarantor- Person responsible for the payment of the patient's medical services.

Coordination of benefits (COB)- Insurance company verification process for payment of claims. They require a patient/guarantor phone call to their insurance plan to verify all insured information before they pay on a claim. COB is time sensitive, and claim may be denied because it took to long to verify (guarantor and insurance company problem).

Recoupment- When an insurance company or guarantor takes back a payment they have previously made, on the patient's behalf, for services rendered. This can occur years later, but commonly occurs a month or two after an insurance plan has been cancelled. Claim resubmission to a new active policy is time sensitive and may be denied if over 60 days (guarantor and insurance company problem).

Non-payment- When an insurance company or guarantor denies payment. Occurs frequently when an insurance plan has been cancelled, a plan has changed or there is a coordination of benefits problem. Claim resubmission to a new active policy is time sensitive and may be denied if over 60 days (guarantor and insurance company problem).

No-response- When an insurance company does not process a claim. Occurs frequently when insurance has changed or there is a coordination of benefits problem or insurance data entry is incorrect. Claim resubmission to a new active policy is time sensitive and may be denied if over 60 days (guarantor, insurance company or provider office problem).

Fee schedule- Discounted schedule of payments that are pre-negotiated by each insurance plan. (Ex: When billed charge =$ 200 and fee schedule= $180 then expected payment cannot exceed $180)

Balance billing- When an out-of-network provider has the right to charge a full amount without a discount. (We do NOT balance bill).

New Patient- Someone that is new to the practice and is establishing care over the first 3 visits.

Old/New Patient- Previously inactive or active patient that has not had an office visit in 3 years.

Active Patient- Someone that has transitioned from New Patient status and desires ongoing care. This may include but is not limited to routine visits and procedures, phone services, telehealth, prescription refill requests, prior authorizations and specialty pharmacy requests.

Inactive Patient- Patient has not transferred care but is not requiring routine services.

Discharged Patient- Patient that has transferred care.

Acknowledgement of Security Deposit Policy:

Patient Name: _____ Guarantor Name:_____

Patient/Parent/Guarantor Signature: _____

Date: _____ (Updated 1/22/24)