

University Specialty Clinics

Self-Pay Patients Guidelines

Purpose

These guidelines are designed to define a fair and consistent method of assigning professional or technical services fees for services provided to those patients without insurance coverage, or who receive services out-of-network contract coverage.

These guidelines will be implemented in an effort to remove any subjective determination of a patient's ability to meet any financial hardship classification, federal or state poverty guidelines or any third party requests to provide a discounted service.

Exceptions

Patients who have insurance coverage that will not pay for certain services considered not meeting coverage criteria of medical necessity (i.e. cosmetic or aesthetic procedures) may be considered self-pay, but are exempt from these billing guidelines and procedures. Departmental usual and customary fees will be applied as deemed reasonable.

Policies

Uninsured self-pay patients will be offered discounts for services provided at rates equivalent to the current year Medicare allowable participating physician rate plus 25% to cover reasonable additional processing and administrative costs. This schedule will be applied uniformly.

Departments that elect to participate should follow the guidelines, procedures and fee recommendations approved and adopted by the University Specialty Clinics/Educational Trust.

Departments may elect to provide individual consideration for patients to pay monthly payments or make other payment arrangement terms. According to South Carolina law, "Truth in Lending" Disclosure Statement should be obtained from the patient even if no finance charges are applied. See **Attachment A**.

Procedures

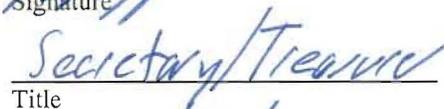
The departmental fee schedule will be posted to the patient's account. Patient Accounts categorized as self-pay will then receive a write-off adjustment to comply with the self-

pay discount. This will allow tracking of the amount of self-pay write-off adjustments. Provided the patient does not establish arrangements, departments will be free to refer those accounts for collections.

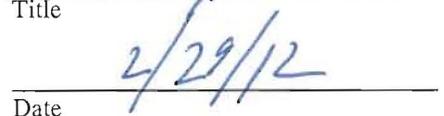
Approved:



Signature



Title



Date

Payment Plan Agreement

Patient Name: _____ DOB: _____

Patient Address: _____

- | | |
|---|-------------|
| 1. Medical/Surgical Fees | \$ _____ |
| 2. Down Payment of Medical/Surgical Fee | \$ _____ |
| 3. Unpaid Balance of Medical/Surgical Fee After Down Payment
(#1 - #2) | \$ _____ |
| 4. Amount To Be Financed | \$ _____ |
| 5. Finance Charge/Annual Percentage Rate | NONE |
| 6. <i>Monthly Payment</i> | \$ _____ |

This disclosure is in compliance with the Truth in Lending Act.

Patient's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____

(Witness certifies the patient has read and understands the above payment plan agreement)