Meritas Health Financial Policy

We value our relationship with our patients. In order to make sure there are no misunderstandings, we wish to inform you of our office policies regarding your financial responsibilities for the services provided.

OUR RESPONSIBILITY

- File Primary insurance claims within a timely filing period following the date of service
- File Secondary insurance claims after the Primary insurance payment is received
- Provide information to your insurance company, as requested
- Contact the insurance carrier if the claim is not paid within 45 days after the claim is filed
- Mail itemized statements to you

YOUR RESPONSIBILITY

- Provide correct insurance and billing information at the time of service
- Pay co-payments at the time of service by cash, check, Visa, Discover, or MasterCard
- Respond immediately to insurance company correspondence regarding claims submitted by Meritas Health on your behalf
- Contact your insurance company if your claim has not been paid, or if you have not received an Explanation of Benefits within 45 days
- Pay all charges upon receipt of the initial statement.
- Call our business office, if you cannot pay your balance in full in 30 days

You are responsible for payment of your account, regardless of insurance coverage. We do not accept responsibility for collecting or negotiating insurance settlements.

We understand that circumstances may sometimes make it difficult for you to pay your balance due in full. Special arrangements must be made with our office to make monthly payments on an account. We must receive a payment from you each month. Past due accounts older than 60 days may be referred to our collection agency.

HOW TO SET UP PAYMENT PLANS

Call Meritas Health Central Services at (816) 436-7072 to make monthly payment arrangements. All accounts must be paid in full within 4 months.

By signing below, you acknowledge that you have read, understand, and agree to the terms of this document relating to payment of your bill.

Patient Signature _____ Date _____
(Parent or Guardian, if patient is a minor)

Name Printed _____ Date of Birth _____