LEARNING OBJECTIVES

1. Define, spell, and pronounce terms listed in the vocabulary.
2. Define bookkeeping and all the different transactions recorded in patient accounts.
3. Do the following related to patient account records:
   • List the necessary data elements in patient account records.
   • Discuss a pegboard (manual bookkeeping) system.
   • Explain when transactions are recorded in the patient account.
   • Perform accounts receivable procedures for patient accounts, including charges, payments, and adjustments.
4. Describe special bookkeeping procedures for patient account records, including credit balances, third-party payments, and refunds; explain how to interact professionally with third-party representatives.
5. Discuss payment at the time of service, and give an example of displaying sensitivity when requesting payment for services rendered.
6. Describe the impact of the Truth in Lending Act on collections policies for patient accounts.
7. Discuss ways to obtain credit information, and explain patient billing and payment options.
8. Review policies and procedures for collecting outstanding balances on patient accounts.
9. Do the following related to collection procedures:
   • Describe successful collection techniques for patient accounts.
   • Discuss strategies for collecting outstanding balances through personal finance interviews.
   • Describe types of adjustments made to patient accounts, including nonsufficient checks (NSF) and collection agency transactions.
10. Define bookkeeping terms, including accounts receivable and accounts payable.
11. Discuss patient education, in addition to legal and ethical issues, related to patient accounts, collections, and practice management.

VOCABULARY

accounts payable The management of debt incurred and not yet paid.
accounts receivable Money that is expected but has not yet been received. The amount charged on the encounter form becomes the account receivable for the healthcare facility.
adjustments Credits posted to the patient account record when the provider’s fee exceeds the amount allowed stated on the EOB.
anti-kickback statute A criminal law that prohibits the exchange of anything of value to reward the referral of a patient sponsored by a government insurance plan.
bookkeeping The recording of financial transactions in the patient account records.
cash on hand The amount of money the healthcare facility has in the bank that can be withdrawn as cash.

While studying this chapter, think about the following questions:
• Why is a continuous flow of income preferable to a once-a-month influx for a provider’s office?
• Why is it important to post charges, payments, and adjustments in a timely manner?
• What should Brenda do when a patient wants to make payments on an outstanding patient account balance?
• What should Brenda do when patient accounts are outstanding for more than 90 days after the date of service?
Every patient encounter is a financial transaction for a healthcare facility. Transactions generated by the patient encounter include a variety of charges, payments, and adjustments that need to be accounted for on a daily basis. Financial management is essential if the owner of a healthcare practice is to pay his or her business operating expenses. If the expenses of operating the healthcare facility exceed the fees collected for services rendered, the business will be forced to close.

A patient account, a running balance of all financial transactions under the patient's account record, is created when the healthcare provider renders services. Charges are applied to the patient account when an encounter form (Figure 16-1) is completed during the office visit; this form lists all the procedures and charges for services rendered.

**BOOKKEEPING IN THE HEALTHCARE FACILITY**

Bookkeeping is the recording of financial transactions in the patient account records. Most healthcare facilities use practice management software for daily bookkeeping transactions. The charges documented on the encounter form are used to complete the health insurance claim form, which shows the diagnosis, procedures, and associated charges. Payments to the healthcare facility come as reimbursement from the insurance company or a patient payment. Adjustments are made to a patient's account when it is necessary to add or subtract an amount, which is not a payment, from the balance; for example, the difference between the provider's charged amount and the contracted insurance payment amount.

**PATIENT ACCOUNT RECORDS**

All charges and payments for professional services are posted to the patient’s account record daily. In this way, the record becomes a reliable source of information for answering all inquiries from patients about their financial responsibilities. The patient account record should include all information pertinent to collecting the account, such as:

- Name and address of the guarantor
- Insurance identification information
- Home and business telephone numbers
- Name of employer
- Any special instructions for billing
- Emergency or alternative contact information

The patient account statement (Figure 16-2) provides a running balance, the result of all of the different financial transactions performed in the account, including charges, payments, adjustments and credits.

**Entering and Posting Transactions in Patient Accounts**

When a practice management software system is used, charges are entered into the record automatically from the encounter form after the office visit.

When a pegboard system is used (see the Manual Bookkeeping box), transactions are initiated before the patient goes to the exam room. The patient account ledger card is inserted under the first or next available receipt, and the first available writing line of the card is aligned with the carbonized strip on the receipt. Enter the receipt number and the date; enter the account balance in the space labeled previous balance; and then enter the patient's name. A copy of the receipt is detached and clipped to the patient's chart to be routed to the provider.

**Posting Charges**

Whether practice management software or a pegboard system is used, the charges posted to the patient’s account should be taken
#### Figure 16-1

*Encounter form with charges. (Courtesy of Bibero Systems, an InHealth Company, Petaluma, Calif.)*
### Financial Statement of College Clinic

**Account No.** 321099  
**Mrs. I. M. Hurt**  
1300 Injury Street  
Woodland Hills, XY 12345

<table>
<thead>
<tr>
<th>Phone No. (H)</th>
<th>(555) 290-1080</th>
<th>(W)</th>
<th>(555) 231-2700</th>
<th>Birthdate</th>
<th>01-05-80</th>
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</thead>
<tbody>
<tr>
<td>Primary Insurance Co.</td>
<td>Prudential Insurance Co.</td>
<td>Policy/Group No.</td>
<td>45621A</td>
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</tbody>
</table>

**4-6-XX**  
**Account No.** 321099  
**Mrs. I. M. Hurt**  
1300 Injury Street  
Woodland Hills, XY 12345

<table>
<thead>
<tr>
<th>Date</th>
<th>Reference</th>
<th>Description</th>
<th>Charges</th>
<th>Credits</th>
<th>Payment</th>
<th>Adj</th>
<th>Balance Forward</th>
<th>Balance</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-6-XX</td>
<td>99203</td>
<td>OV, Level 3, NP</td>
<td>70.92</td>
<td></td>
<td></td>
<td></td>
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<td>4-6-XX</td>
<td>93000</td>
<td>EKG</td>
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<td></td>
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<td></td>
<td>105.18</td>
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<td>5-10-XX</td>
<td>99212</td>
<td>OV, Level 2</td>
<td>28.55</td>
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<td>133.73</td>
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<tr>
<td>5-14-XX</td>
<td>99222</td>
<td>Hosp admit, C Hx/PX</td>
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<td></td>
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<td></td>
<td>254.53</td>
<td></td>
<td></td>
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<tr>
<td>5-15-XX</td>
<td>51900</td>
<td>Closure of vesicovaginal fistula</td>
<td>1196.82</td>
<td></td>
<td></td>
<td></td>
<td>1451.35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-16-XX</td>
<td>99024</td>
<td>HV</td>
<td>NC</td>
<td></td>
<td></td>
<td></td>
<td>1451.35</td>
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<td>Discharge</td>
<td>NC</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>5-30-XX</td>
<td>4/6-5/15</td>
<td>Billed Prudential Insurance Company</td>
<td></td>
<td></td>
<td></td>
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<td>1451.35</td>
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<td></td>
</tr>
<tr>
<td>7-3-XX</td>
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<td>ROA Prudential Ins Co</td>
<td>980.30</td>
<td></td>
<td></td>
<td></td>
<td>471.05</td>
<td></td>
<td></td>
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<tr>
<td>7-3-XX</td>
<td>4/6-5/15</td>
<td>Insurance Contract adj. (Prudential)</td>
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<td></td>
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<td></td>
<td>245.07</td>
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<td></td>
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<td>8-14-XX</td>
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<td>0</td>
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<td></td>
</tr>
</tbody>
</table>

**PLEASE PAY LAST AMOUNT IN BALANCE COLUMN**

**THIS IS A COPY OF YOUR FINANCIAL ACCOUNT AS IT APPEARS ON OUR RECORDS**

**FIGURE 16-2** Patient account statement. (From Fordney WT: Insurance handbook for the medical office, ed 14, St. Louis, 2017, Elsevier.)

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From the **provider’s fee schedule**. Patient account management software systems automatically put in the correct fees or charges when a CPT/HCPCS* code is entered (Procedure 16-1).

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When checking out a patient using a pegboard system, the medical assistant should insert the ledger card under the proper receipt and check the number previously entered to make sure the correct card is being used. Record the service by procedure code, post the charge from the fee schedule, enter any payment made, and write in the current balance. If there is no balance, place a zero or a straight line in the balance column.
UNIT FOUR  MEDICAL OFFICE ADMINISTRATIVE FUNCTIONS

EQUIPMENT  and  SUPPLIES
•  Patient account ledger card
•  SimChart for the Medical Office software
•  Encounter form/Superbill
•  Provider’s fee schedule

Scenario 1: Ken Thomas is a returning patient of Dr. Martin. He makes his $50 copayment at the time of the office visit.

Scenario 2: Martha Bravo is seeing Dr. Walden. He is being seen for hypertension (ICD-10-CM I10) for the first time for hypothyroidism (ICD-10-CM E03.9). She makes the $30 copayment at the time of the office visit.

Goal: To enter charges into the patient account record manually and electronically.

PROCEDURE 16-1 Perform Accounts Receivable Procedures for Patient Accounts: Charges

PROCEDURAL STEPS

Posting Charges Manually
1. For new patients, create the patient account by entering the following information on a patient account ledger card:
   •  Patient’s full name, address, and at least two contact phone numbers
   •  Date of birth
   •  Health insurance information, including the subscriber number, group number, and effective date
   •  Subscriber’s name and date of birth (if the subscriber is not the patient)
   •  Employer’s name and contact information

 PURPOSE: To keep all insurance and collection information available with the patient account record balance for reference.

2. For returning patients, review the account record to see whether a balance is due. If there is a balance, bring this to the patient’s attention when he or she comes for the appointment. Respectfully explain that the provider would appreciate a payment on the previous balance before he or she can care for the patient. Use the following dialogue:

 Brenda:  Good morning, Ken. How are you feeling today?
 Ken:  Not so good, I really need to see Dr. Martin again because my headaches have been getting worse.

 Brenda:  I’m sorry to hear that. Let’s get you in to see the doctor right away. I can collect the $50 copayment for today’s visit, and here is a statement for your previous balance of $214. How would you like to take care of that today?

 Ken:  Oh, I didn’t know about the previous balance. Can I just pay the copayment today?

Although we live in a technology-savvy world, many providers still use a manual pegboard system. In many cases, providers who have been in practice for many years do not want to invest in a patient account software system because the manual system is so logical and practical to use.

Some certifying exams still include questions about manual systems. If the office experiences a power outage, the employees will have to use a manual system for the period in which patients are seen while the power is out. The medical assistant must be familiar with both manual and electronic patient account management systems. The pegboard is the most popular manual system for this purpose. It is simple to operate, and once a medical assistant learns the pegboard system, computer systems are much easier to understand.

The pegboard system gets its name from the lightweight aluminum or Masonite board that is used. This board has a row of pegs along the side or top that holds the forms in place. The patient account ledger cards are perforated for alignment on the pegs. All the forms used in any system must be compatible so that they can be aligned perfectly on the board.

The pegboard system generates all the necessary financial records for each transaction (by writing once with carbon paper) as follows:
•  Encounter form
•  Receipt
•  Patient account ledger card
•  Bookkeeping transaction entry

The system also may include a statement and bank deposit slip. It provides current accounts receivable totals and a daily record of bank deposits and cash on hand, in addition to the record of income and expenses. The need for separate posting to patient accounts is eliminated, and the chance for error is reduced.

The pegboard system allows the medical assistant to keep control over cash, collections, and receivables and ensures that every cent is accounted for and properly entered. It provides a record of every patient, every charge, and every payment, plus a daily recap of earnings—a running record of receivables and an audited summary of cash—and requires little time.

Employer Information
Name: Malibu Gardening
Contact: (212) 555-5151
PROCEDURE 16-1 —continued

Brenda: Dr. Martin would like at least half of this previous balance paid before seeing you today, please. I know that medical bills can pile up pretty quick, but Dr. Martin would like to continue to provide you with quality care so you can feel back to yourself really soon.

Ken: Yes, I know you’re right. I need to keep coming to see Dr. Martin. I can pay half of the $214 today, along with the copayment.

Brenda: Thanks, I know Dr. Martin really appreciates you as a patient. Would that be check or credit card?

Ken: Credit card, please.

Brenda: Okay, here is the credit card receipt and a copy of the updated statement. By the way, I’d like to document on your patient account when you will be able to pay the rest of this statement amount.

Ken: I’ll pay the balance next month; is that okay?

Brenda: I’ll let Dr. Martin know and put a note in your account. Thanks; you’ll be called in shortly.

PURPOSE: To respectfully inform the patient of his or her financial obligations and the provider’s intention of having the previous balance paid in full.

3. After seeing the patient, the provider completes the encounter form, which includes all procedures and the associated fee schedule. Using the completed encounter form (see Figure 16-1), enter the charges manually on the ledger card for the patient’s account record. Total all the charges on the encounter form for the services rendered. Then subtract the copayment made from the total charges. The previous balance, if any, is added to this new total. Use the following worksheet to calculate the new balance. The new balance-due amount should be presented to the patient before he or she leaves the healthcare facility.

| Total Charges | $ ____________ |
| Amount paid (copayment) | $ ____________ |
| + Previous balance (if any) | $ ____________ |
| = New Balance Due | $ ____________ |

PROCEDURAL STEPS

Posting Charges in SimChart for the Medical Office

1. After logging into SimChart, locate the established patient by clicking on Find Patient, enter the patient’s name, verify DOB, and click on the radio button. This will bring you to the Clinical Care tab. If there is no encounter shown, create an encounter by clicking on Office Visit under Info Panel on the left, select a visit type, and click on Save. Once an encounter has been created, return to the Patient Dashboard and click on the Superbill link on the right (or click on the Coding and Billing tab).
PROCEDURE 16-1 —continued

2. From the Superbill area, in the Encounters Not Coded section, click on the encounter (in blue). On page 1 enter the diagnosis in the Diagnosis field and document the services provided (additional services are found on pages 2-3 of the Superbill).
3. Complete the information needed on page 4 of the Superbill and submit.
4. Click on Ledger on the left and search for your patient. Once your patient has been located, click on the arrow across from the name in the ledger.
5. Enter the services provided and the payment received. Click on the Add Row button to continue to add services. The balance will be auto-calculated for you.

Posting Payments

All payments, including those received by mail or electronically, or when the patient pays the copay at the time of the appointment, are entered into the patient’s account as a credit.

Payments should be posted by line item corresponding to the submitted health insurance claim (Procedure 16-2). All insurance payment amounts posted should match the total amount paid on the Explanation of Benefits (EOB) (Figure 16-3).

Posting Adjustments

Adjustments are credits posted to the patient account record when the provider’s fee exceeds the amount allowed stated on the EOB. Adjustments should always be posted to the patient account record at the same time as the payment. Under the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, healthcare providers may not discount the patient’s financial responsibility after the health insurance has paid its portion.

PROCEDURE 16-2

Perform Accounts Receivable Procedures in Patient Accounts: Payments and Adjustments

Goal: To process payments and adjustments to patient accounts records accurately.

EQUIPMENT and SUPPLIES

• Patient account ledgers card, or SimChart for the Medical Office software
• Explanation of Benefits (EOB) (see Figure 16-3)

PROCEDURAL STEPS

Posting Payments and Adjustments Manually

1. Review the EOB for multiple patient accounts received by the healthcare facility.
2. Look up the ledger card for the patient account (or the patient ledger in SimChart) and compare the date of service on the EOB and with the date shown on the ledger card. Also, compare the amount charged for the dates of service; both the date of service and the amount charge should match on the two documents.

PURPOSE: To confirm that the payment and adjustment posted are shown for the correct patient, date of service, and procedure.
3. Post the payment and adjustment line by line. To confirm the accuracy of the figures, the following formula can be used:

Total charged = Insurance payment amount + Amount adjusted + Patient responsibility or Secondary insurance responsibility

Posting Payments and Adjustments in SimChart

Use a new line on the patient ledger in the patient account to post an insurance payment.

1. After one line on the EOB has been posted, post all subsequent lines on the EOB separately.
2. Confirm that the adjustment was necessary on the EOB (Figure 1). Review the amount paid. If there is concern that the amount adjusted was too much, either review the provider’s contract with the insurance company’s fee schedule to compare payments, or call the insurance company’s provider services to inquire about the applicable adjusted amount.

PURPOSE: Adjustments may be necessary in cases of disallowed charges, noncovered services, and so on.
3. When the patient’s financial responsibility has been established, send the patient a statement. The secondary insurance should be billed if the patient is covered.
Therefore, providers can adjust only the amount in the patient account approved by the health insurance company. The only other circumstance in which an adjustment can be made is when a patient or guarantor files for bankruptcy; the entire patient account balance then must be adjusted off the books.

The patient account record should have a column for the adjustment to be posted as a credit. Remember, payments and adjustments are both credits; however, payments are money that is received in the healthcare facility, and adjustments simply reduce the balance the patient owes on the account. When the payments and adjustments are subtracted from the charged amount, the balance is either the patient responsibility or the amount billed to the secondary insurance.

Before continuing to post to the next EOB line item, confirm that the payment amount, the adjusted amount, and the patient responsibility/secondary insurance balance match exactly the amounts calculated on the EOB (see Procedure 16-2).

**Special Bookkeeping Entries for Patient Account Records**

The following special bookkeeping entries are sometimes necessary to keep the patient account record in balance. They may be performed either with the practice management software or a pegboard system:

- Credit balances
- Third-party payments
- Refunds

**Credit Balances**

A credit balance occurs when a patient has paid in advance, or an overpayment or duplicate payment is made. For example, an overpayment occurs if the patient makes a partial payment and later the insurance allowance is more than the remaining balance. When this happens, the patient account will show a credit balance, or an amount that the provider owes. The medical assistant should
FIGURE 16-3 Explanation of Benefits (EOB). (From Fordney MT: Insurance handbook for the medical office, ed 14, St Louis, 2017, Elsevier.)
investigate to whom the credit balance is owed (i.e., the patient or the insurance company). The first place to investigate is the EOB from the insurance company; this document shows the exact amount of the patient’s financial responsibility. The medical assistant should confirm that all the line items match the corresponding amounts on the EOB because many credit balances are created when an error is made in payment posting. If the patient’s payment exceeded the amount indicated on the EOB, the provider must send a check for the balance to the patient. A credit balance creates a debit in the patient account, or an amount that is due by the provider to the patient or the insurance company, depending on which party made the overpayment.

**Third-Party Payments**

*Third-party payments* are reimbursement payments made by an insurance company that provides benefits for the patient. In other words, third-party payers pay the healthcare provider on behalf of the patient. Once the third party pays the insurance claim for the date of service, the total owed to the provider becomes the amount charged minus the payment amount and the amount adjusted by the third party. The remaining balance is still owed to the provider by the patient.

The total charged = insurance payment amount + amount adjusted + patient responsibility or secondary insurance responsibility.

**Refunds**

Just like credit balances, refunds create a credit in the patient account that needs to be accounted for. Refunds are returned payments made to the insurance companies for overpayments made on patient accounts. Sometimes overpayments occur if the health insurance company pays for the same patient, date of service, and procedures more than once by accident. The medical assistant should compare the original EOB to the second EOB to confirm that an overpayment has occurred. If both EOBs show the same payment for the same date of service, refund one payment. If the two EOBs show different payments, call provider services for the health insurance plan to ensure proper payment to the patient account. The healthcare facility cannot keep the higher payment and return the overpayment.

The total charged = insurance payment amount + amount adjusted + patient responsibility or secondary insurance responsibility.

**CRITICAL THINKING APPLICATION 16-1**

The healthcare facility receives two checks for a patient, Kelly Washington, from Blue Cross for the same date of service. One check is for $438, and the other is for $534. Can Brenda post the larger payment and just refund the smaller payment to Blue Cross? What must Brenda do before she posts either payment?

**Interacting With Third-Party Representatives**

Most health insurance plans sponsor an online provider Web portal for checking on verification of eligibility and claim status. However, in some circumstances medical assistants must interact with third-party representatives. This can be a time-consuming process involving waiting on hold on the telephone for long periods; nevertheless, medical assistants represent their healthcare facility, and they still must interact professionally. Here are some tips for interacting with third-party representatives:

- Before calling provider services, have all documents readily accessible to discuss the patient account
- Use headphones so that the music played while the phone call is on hold does not disturb the rest of the office
- If a long wait time is expected, work on other tasks that do not require phone use
- When the health insurance representative comes on the phone, refrain from telling him or her how long the wait was; representatives usually do not have much control over wait times
- Use the documents set aside for the phone call to confirm the patient’s identity quickly so as to get to the purpose of the call
- Document the details of the phone conversation with the health insurance representative in the patient account record, including the representative’s name and the date and time of the call
- If the conversation is a follow-up call, share the details collected from the previous call from notes documented in the patient account record

**CRITICAL THINKING APPLICATION 16-2**

Brenda received a claim denial for a patient, Clara Martin, for date of service 1/11/20XX. The denial stated that Ms. Martin was not covered on this date of service. Brenda reviewed her notes in the patient’s account and found the verification of eligibility that was done on 1/11/20XX for Clara Martin. What should Brenda do to prepare to call the insurance company?

**Payment at the Time of Service**

Healthcare facilities accept the patient’s health insurance card and copayment as good faith that the practice will be paid for the services rendered. For the most part, patients are expected to pay their copayment at the time of service unless previous arrangements have been made (Figure 16-4). Patients without health insurance should pay...
after the charges for the day have been totaled. Patients should be informed when making an appointment that payment is expected at the time of service so that they are not surprised when asked for payment at the healthcare facility. The medical assistant may say, “Your charge for today is $25. Will that be cash, check, credit, or debit card?” If a patient asks to be billed, the medical assistant may say, “Our normal procedure is to pay at the time of service unless other arrangements are made in advance.”

Displaying Sensitivity When Requesting Payment

The medical assistant must believe that the provider has a right to charge for the services rendered. Do not be embarrassed to ask for payment for the valuable services that have been provided. Remember that the practice is a business, and the provider must meet the obligations involved in keeping it fiscally healthy, including salary expenses. When tact and good judgment are used in billing and collecting, patients appreciate the service they receive and the help the medical assistant provides. Give each patient individual attention and personal consideration; also, be courteous and show a sincere desire to help the patient with financial problems.

CRITICAL THINKING APPLICATION 16-3

Adam Page comes to the front desk to pay his copay with a credit card. His card is declined. How can Brenda handle the situation? What options could be offered to Mr. Page to make a payment at the time of service?

Billing After a Payment Agreement Has Been Made

Most providers prefer payment before or at the time of service. However, if fees for surgery or long-term or expensive therapy are involved, payment arrangements become necessary, and a regular system of billing must be established. The medical assistant therefore must explain to the patient the professional fees, the services the charges cover, and the office credit policies. In most healthcare practices, the appropriate staff member sits down with the patient for a financial consultation before a payment arrangement contract is offered (Figure 16-5). The payment arrangement contract states the monthly payment; how many months it must be paid; the payment due date; whether interest will be charged; and the penalties of nonpayment.

Using Credit for Medical Services

Some healthcare facilities distribute information about credit cards or loans available specifically for healthcare treatments. This is very popular for cosmetic surgeries, dental procedures, and laser eye surgeries. Offices that offer these types of procedures may want to investigate such alternative financing services. Although these options are valuable when used properly and repaid on time, they do create additional debt for the patient. As an alternative, the healthcare facility may allow the patient to split large healthcare expenses into two or three interest-free lump sum payments so that the patient does not incur credit card interest charges.

TRUTH IN LENDING ACT

When offering credit options for patients, the medical practice should be in compliance with Regulation Z of the Truth in Lending Act (TILA). TILA is enforced by the Federal Trade Commission (FTC) and is part of the Consumer Credit Protection Act. TILA requires that individuals be provided certain information when credit is extended, including the annual percentage rate (APR), the terms of the loan, and the total costs to the borrower. If an agreement exists between provider and patient that the practice will accept full payment in more than four installments, the practice must provide a Federal Truth in Lending Statement (Figure 16-6), even if no finance fees are charged. The statement is signed by the practice’s representative and the patient.

Healthcare facilities occasionally allow their patients to pay in installments (although this practice is much less common than in the past). As long as no specific agreement has been made for payment to the provider in more than four installments and no finance charge is assessed, the account is not subject to TILA and does not require a signed Truth in Lending Statement.

OBTAINING CREDIT INFORMATION

Credit information is confidential. It should be guarded as carefully as confidential health information and should never be disclosed to unauthorized individuals. If a call is received about a patient’s credit history, follow the healthcare facility’s policy, based on regulations established by the Health Insurance Portability and Accountability Act (HIPAA) and legal guidelines in your state. When asking for credit information from patients in the office, do so in a private area where others cannot overhear the conversation. A patient should be able to complete a credit application in an area separate from the reception area, where the patient can sit in total privacy. Never access a credit report on patients unless it is necessary to process an application for credit privileges at the healthcare facility and the patient authorizes it.

MONTHLY PATIENT ACCOUNT STATEMENTS

Healthcare facilities should send monthly statements for all patient account records that have a balance due. These statements should be...
Medicare Advance Beneficiary Notices

Medicare does not cover some healthcare services so the Advanced Beneficiary Notice (ABN) is presented to patients in these circumstances. The ABN provides an option for patients to pay the provider’s fee in full to receive services that Medicare does not cover. The patient decides whether he or she still wants to receive the services from the provider and completes the information on the form (Figure 16-7).

Professional Courtesy

In the past some providers did not charge professional colleagues or their close family members for medical care; this concept is called professional courtesy. However, this has led to fraud in the industry because some providers would recommend patients to auxiliary facilities from which the provider would receive compensation for the referral. The Stark law, which was passed to eliminate such fraud, imposes the following restrictions on professional courtesy:

- The professional courtesy must be extended to all members of the healthcare facility, not just a single provider
- The services provided must be routine for the healthcare facility extending the professional courtesy

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**PATIENT AGREEMENT**

Patient’s Name          James Doland                            Soc. Sec. #  431-XX-1942
Address   67 Blyth Dr., Woodland Hills, XY 12345          Tel. No. 555-372-0101
WC Insurance Carrier  Industrial Indemnity Company         Address  30 North Dr., Woodland Hills          Telephone No. 556-731-7707
Date of illness  2-13-20XX              Date of first visit  2-13-20XX
Emergency   Yes  X  No
Is this condition related to employment   Yes  X  No
If accident:  Auto_______Other________ Where did injury occur?  Construction site
How did injury happen?  fell 8 ft from scaffold suffering fractured right tibia
Employee/employer who verified this information  Scott McPherson  
Employer’s name and address  Willow Construction Company  
Employer’s telephone no. 555-526-0611

In the event the claim for workers’ compensation is declared fraudulent for this illness or condition or it is determined by the Workers’ Compensation Board that the illness or injury is not a compensable workers’ compensation case, I, James Doland, hereby agree to pay the physician’s fee for services rendered.

I have been informed that I am responsible to pay any services rendered by Dr. Raymond Skeleton with regard to the discovery and treatment of any condition not related to the workers’ compensation injury or illness. I agree to pay for all services not covered by workers’ compensation and all charges for treatment and personal items unrelated to my workers’ compensation illness or injury.

Signed    James Doland          Date  2-13-20XX

**FIGURE 16-5** Patient payment agreement. (From Fordney MT: Insurance handbook for the medical office, ed 14, St Louis, 2017, Elsevier.)
According to federal regulations, minors cannot be held financially responsible for their patient account balance unless they are emancipated. Bills for minors are usually addressed to a parent or legal guardian. If a bill is addressed to a minor, parents could take the attitude that they are not responsible because they never received a statement.

If the parents are separated or divorced, the parent who brings the child in for treatment is responsible for payment. Whatever financial agreement exists between the parents is strictly their personal business and should not concern the healthcare practice. The responsible parent should be so informed from the first appointment.

If a minor appears in the office and requests treatment, and you can ascertain that the person is legally emancipated, the minor can assume financial responsibility. It may be wise to make a determination either with the office manager or with the provider as to whether the office wishes to treat an emancipated minor. Minors can be treated for certain conditions, such as sexually transmitted diseases (STDs), pregnancy, and birth control, without parental consent. In these cases, the medical assistant must determine where the patient account statement should be sent.

### Medical Care for Those Who Cannot Pay

The medical profession traditionally has accepted the responsibility of providing medical care occasionally for individuals unable to pay for these services. Despite the increased scope of government-sponsored care for the **medically indigent**, providers still spend thousands of dollars each year providing services before securing some type of payment.

In many instances medical care of the indigent is available through social service agencies. Medical assistants should learn about local organizations and agencies that can aid patients in obtaining the necessary assistance. The provider can provide only medical services. Other agencies provide hospitalization, for example, or arrange for paying the costs of special therapy, rehabilitation, or medications. Unfortunately, another segment of the population consists of uninsured employees who are not eligible for public assistance, are not covered under a group policy, and cannot afford the high premiums for private medical insurance. Give special attention to helping these people arrange payment of their medical bills. If a provider accepts a case in advance for which a fee will not be paid, complete records must still be kept on the patient. The only deviation in procedure is that the financial record indicates no charge in the debit column.

### Fees in Hardship Cases

Sometimes a healthcare practice is faced with the problem of deciding whether to reduce or cancel a fee in a hardship case. Before adjusting or canceling a fee, the provider or medical assistant should have a frank discussion with the patient about his or her financial situation. Find out whether the patient is entitled to or qualifies for medical assistance. For instance, if the patient's injuries are the result of a car accident, there may be medical insurance through the automobile policy. Circumstances may qualify the patient for local or state public assistance, such as crime victim assistance. Maintain information about such agencies that are available in the area and direct the patient to the appropriate one.

Discuss the fee in advance and make payment arrangements if the circumstances of hardship are known before services are rendered. The healthcare practice may suggest that a medically indigent patient seek care at a county hospital with public assistance. A provider should be free to choose his or her form of charity and should

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**Billing Minors**

According to federal regulations, minors cannot be held financially responsible for their patient account balance unless they are emancipated. Bills for minors are usually addressed to a parent or legal guardian. If a bill is addressed to a minor, parents could take the attitude that they are not responsible because they never received a statement.

**FIGURE 16-6** Truth in Lending Statement. (Courtesy Colwell Systems, Champaign, Ill.)

- The professional courtesy must be set forth in writing in advance by the healthcare facility's board of directors
- The professional courtesy cannot be extended to Medicare patients or other federal beneficiaries unless there is documentation of financial need
- The professional courtesy cannot violate any anti-kickback statute or state law

**CRITICAL THINKING APPLICATION 16-4**

Dr. Wilkins has just finished seeing Dr. James Franklin, who came to her as a patient. Dr. Franklin insists to Brenda that Dr. Wilkins always extends him professional courtesy. Brenda is not aware of an approved professional courtesy agreement with Dr. Franklin. However a professional courtesy agreement with Dr. Franklin is not on file. Whom should Brenda talk to?
not feel obligated to substantially reduce or cancel a fee when the circumstances are known in advance.

The provider and the patient may agree on a fee, but special circumstances may subsequently arise that create a hardship. If the provider agrees to reduce the fee, the patient should be told that the reduction will be effective only after the adjusted amount is paid in full. For instance, if a fee of $500 is reduced to $350, the full amount of the $500 charge should appear on the ledger, and when $350 has been received, the remainder can be written off as an adjustment.

### Pitfalls of Fee Adjustments

Problems can arise when a provider begins to reduce his or her fees. Patients may begin to expect fees to be reduced in all circumstances. Patients may even doubt the competency of a provider who habitually reduces fees. Make fee reductions the exception rather than the norm.

Take great care in reducing the fee for care of a patient who dies. The provider’s sympathy is with the family in such instances, but generosity in reducing a fee could be misinterpreted and result in a suit for malpractice. The family may suspect that the fee was reduced because the provider knows he or she made an error.

If the provider agrees to settle for a reduced fee in a situation in which the patient is disputing the cost, ensure the negotiations are “without prejudice.” By taking this precaution, the provider protects his or her right to collect the original sum should the patient refuse to pay the lowered fee. The discount offer, therefore, should be made in writing; should include the words “without prejudice”; and should state a definite time limit for making payment. Prepare two copies of the agreement and have the signatures witnessed by a staff member.

A fee should never be reduced because of poor results or as a means of obtaining payment to avoid the use of a collection agency. A fee reduction for these reasons degrades the provider and the practice of medicine.

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**FIGURE 16-7 Advance Beneficiary Notice for Medicare patients.** (From Fordney MT: Insurance handbook for the medical office, ed 14, St Louis, 2017, Elsevier.)

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**Advance Beneficiary Notice of Noncoverage (ABN)**

<table>
<thead>
<tr>
<th>D.</th>
<th>E. Reason Medicare May Not Pay</th>
<th>F. Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>B12 injections</td>
<td>Medicare does not usually pay for this injection or this many injections</td>
<td>$35.00</td>
</tr>
</tbody>
</table>

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. B12 injections listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS:** Check only one box. We cannot choose a box for you.

- **OPTION 1.** I want the D. B12 injections listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- **OPTION 2.** I want the D. listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- **OPTION 3.** I don’t want the D. listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

**H. Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

**I. Signature:** [Sign Here]

**J. Date:** [Date Here]
COLLECTION PROCEDURES

When to Start Collection Procedures

Collection is the process of using all legal resources available to collect payment for past due patient account balances. Sometimes a patient may have difficulty meeting all of his or her financial obligations. The patient may have lost a job or insurance coverage. An emergency could arise that depletes finances. When patients must choose between paying their medical bills and having electricity, the provider often is forced to wait for payment. Although a few patients absolutely refuse to pay for their medical care, most are honest and willing to pay but may need help with a payment plan. Terms can be arranged for collecting payment in full when the office and the patient cooperate with each other. The medical assistant should attempt to work out a plan that the patient can abide by, and the patient should be expected to make promised payments.

Preparing Patient Accounts for Collection Activity

Sometimes it becomes necessary to aggressively attempt to collect the balances that patients owe the practice. Persuasive collection procedures include telephone calls, collection reminders and letters, and personal interviews.

Before you begin collection action, it is essential to determine which accounts have a balance due and how old the account balance is. Some accounts are grouped together, or “aged,” according to the dates of the last payment activity, whereas others are grouped according to the original date of service. Patient account management software programs can create aging patient account reports that are grouped by month, beginning with the month the bill was first charged (Figure 16-8). Common account aging categories are:

- 0-30 days
- 30-60 days
- 60-90 days
- 90-120 days

Most bills with balances less than 30 days old are probably waiting for the health insurance to reimburse, so no collection action is needed. Patient account balances more than 90 or 120 days old require a final demand letter before the account is turned over to a collection agency. Always allow the provider to review and approve the list of patient accounts being sent to a collection agency. Once patient account balances are aged, follow the most appropriate collection activity, according to the practice’s policy.

The medical assistant can use a variety of techniques to collect patient accounts, such as collection phone calls, collection letters, and skip tracing. Often more than one technique must be used to obtain payment. Always be courteous and kind when using all collection techniques.

Collection Phone Calls

A telephone call at the right time, in a negotiable demeanor, is more successful than notes, patient account statements, or collection letters. The personal contact call often prompts patients to mail in their payment or to make payments over the phone with a credit card. In the absence of time to make calls, the collection letter is the next best approach, but if collections are a serious problem, it may be worth an extra salary to hire a person to make the phone calls.

Always treat patients with the utmost respect on the telephone. Keep their financial record close by in case they have questions about their bill; also have their insurance company’s phone number handy. Remember that some patients may not understand anything about insurance or third-party payers, so guide them to that understanding and be their advocate in getting as much reimbursement as possible so that the patient’s share is smaller. Never simply insist that the insurance plan has paid and the patient’s balance is due. This puts the patient in a negative mindset. Try using phrases such as the following:

- “Mrs. Diggs, it looks as if your insurance company paid late last month. I believe you have a co-insurance for your surgery which amounts to $450. Is that what you were expecting? Would you like to take care of the whole balance or split that into two payments? Let me review some of your payment options.”
- “Mr. Hildebrand, we’re showing that you have a balance due from your surgery. Your insurance has paid, and it looks as if you owe $700. We would be happy to help you by splitting that into two or three payments. When can I schedule that first payment for you?”
- “Mrs. Crumley, it seems that you have a balance due of $450 from your surgery, and I called to see whether I could help you budget that. You could pay $50 this week and split the remaining $400 into two payments over the next 2 months?”

Always abide by office policy when making payment arrangements in collection situations. Never be belligerent with a patient.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Acct #</th>
<th>Primary Insurance</th>
<th>Secondary Insurance</th>
<th>Aging Analysis</th>
<th>Total Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bassett, Eleanor</td>
<td>75846</td>
<td>AETNA</td>
<td></td>
<td>$145.00 $0.00 $0.00 $0.00 $0.00 $145.00</td>
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<td>Herron, John</td>
<td>83029</td>
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<td></td>
<td>$0.00 $42.41 $0.00 $0.00 $0.00 $0.00 $42.41</td>
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<tr>
<td>Holt, Maxine</td>
<td>64739</td>
<td>AETNA</td>
<td>BLUE SHIELD</td>
<td>$145.00 $0.00 $0.00 $145.00 $0.00 $145.00</td>
<td></td>
</tr>
<tr>
<td>Kellog, Keenan</td>
<td>24537</td>
<td>AETNA</td>
<td></td>
<td>$0.00 $0.00 $145.00 $0.00 $0.00 $145.00</td>
<td></td>
</tr>
<tr>
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<td>85940</td>
<td>AETNA</td>
<td></td>
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<td></td>
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<td>Markham, Melanie</td>
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<td></td>
<td>$0.00 $0.00 $0.00 $260.00 $0.00 $260.00</td>
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<td>McDonald, Lydia</td>
<td>56374</td>
<td>AETNA</td>
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<td>$260.00 $0.00 $0.00 $260.00 $0.00 $260.00</td>
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<tr>
<td>McLean, Mary</td>
<td>24395</td>
<td>AETNA</td>
<td></td>
<td>$0.00 $0.00 $0.00 $260.00 $0.00 $260.00</td>
<td></td>
</tr>
<tr>
<td><strong>Aetna Aging Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$550.00 $57.41 $145.00 $260.00 $260.00 $1,272.41</strong></td>
<td></td>
</tr>
</tbody>
</table>

FIGURE 16-8 Sample aging report. (From Fordney MT: Insurance handbook for the medical office, ed 14, St Louis, 2017, Elsevier.)
If he or she becomes irate, simply state that the person can call back when ready to discuss a solution for paying the account, say goodbye, and gently hang up the phone. Never listen to expletives or allow verbal abuse. Respectfully end the phone call by saying thank you and good bye; do not slam the phone.

Written notification is a must before making a final demand for payment indicating that legal or collection proceedings will be started. Each patient account should be handled individually on the basis of the experience with the patient involved.

General Rules for Telephone Collections

**What to Do**

- Call the patient when it can be done privately.
- Call only between 8 AM and 9 PM.
- Determine the identity of the person with whom you are speaking. If you ask, “Is this Mrs. Noble?” and she answers, “Yes,” it could be the patient’s mother-in-law or daughter-in-law, who is also “Mrs. Noble.” Use the person’s full name. Include suffixes, such as “Thomas Melborn, III.” This may sound too formal, but it helps to ensure that the correct person is on the phone.
- Be dignified and respectful. One can be friendly and professional at the same time.
- Ask the patient whether it is a convenient time to talk. Unless you have the attention of the called party, there is little to be gained by continuing. If told that it is an inopportune time, ask for a specific time to call back or get a promise that the patient will call the office at a specified time.
- After a brief greeting, state the purpose of the call. Make no apology for calling, but state the reason in a friendly, business-like way. The provider expects payment, and the medical assistant is interested in helping the patient meet the financial obligation. Open the call with a phrase such as, “This is Alice, Dr. Crawford’s medical assistant. I’m calling about your account.” A well-placed pause at this point in the call sometimes gets an immediate response from the debtor with regard to the nonpayment.
- Assume a positive attitude. For example, convey the impression that the patient intended to pay, and it is only a matter of working out some suitable arrangements.
- Keep the conversation brief and to the point; do not make threats of any kind.
- Try to get a definite commitment—payment of a certain amount by a certain date.
- Follow up on promises made by the patient. This is best accomplished by using a tickler file or a note on the calendar. If the payment does not arrive by the promised date, remind the patient with another call. If the medical assistant fails to do this, the whole effort has been wasted.

**What Not to Do**

- Do not call between 9 PM and 8 AM. To do so may be considered harassment.
- Do not make repeated telephone calls on the same day.
- Do not call the debtor’s place of work if the employer prohibits personal calls.
- If a call is placed to the debtor at work and the person cannot take the call, leave a message asking the debtor to “call Mrs. Black at 951-727-9238” without revealing the nature of the call; that is, do not state that the call is from “Dr. Crawford’s office” or “Dr. Crawford’s medical assistant.”
- Refrain from showing any kind of hostility. An angry patient is a poorly paying patient. Insulted patients often do not pay at all.

Collection Letters

Some consultants believe that a printed collection letter or reminder enclosed with a statement is more effective than a personal letter. Their attitude is that a patient may be embarrassed by a personal letter and feel that he or she has been singled out for attention. An impersonal printed message will probably encourage the debtor to send a payment.

Letters that are friendly requests for an explanation of why payment has not been made are effective in most cases. These letters should indicate that the provider is sincerely interested in the patient’s health and well-being and wants to help resolve the financial obligation. Invite the patient to the office to explain the reasons for nonpayment so that payment arrangements can be made. To lessen the patient’s embarrassment, these letters can suggest that previous statements may have been overlooked.

When receiving these letters, most patients make some effort to explain their failure to make payment. If a patient really is having financial difficulties, he or she may be able to get public assistance. If it is a temporary financial problem, the provider and the patient may together be able to work out a satisfactory installment plan for payment.

The medical assistant often is given a free hand in designing collection patterns and composing collection letters. Many medical assistants compose a series of collection letters using example letters they have found effective. Such a series usually includes at least five letters in varying degrees of forcefulness.

Sometimes even a person with poor paying habits will pay if treated with respect and consideration. The medical assistant should never go beyond the authority granted by the provider in pursuing collections. If questions arise about special collection problems, always check with the provider before proceeding. This is particularly important with patients you do not know personally (e.g., patients the provider has seen in the hospital or at home and patients with no credit history). It is difficult to say whether the effects of pressing collections too hard (which can result in loss of patient good will) are more detrimental than the effects of not pursuing collections diligently enough (which can result in loss of revenue). The provider and the medical assistant should agree on general collection policies, as outlined earlier in this chapter, and the policies should be followed. In all cases in which an account is to be assigned to a collection agency, make sure the provider is aware of this and approves.

In most healthcare facilities, the medical assistant signs collection letters using his or her title, such as “Medical Assistant” below the typewritten signature. Do not list “Collections” below the name, because the patient may assume that the account has been placed with a collection agency. Some providers want to sign these communications personally, but generally the medical assistant who handles the patient accounts also signs the collection letters.
Personal Finance Interviews

Personal finance interviews with patients sometimes can be more effective than a whole series of collection letters. By speaking with a patient face to face, the medical assistant can come to an understanding of the problem more quickly, and an agreement about future payment plans can be reached (Figure 16-9).

Occasionally a patient may undergo a long course of treatment and yet make no attempt to pay anything on the account. Perhaps such a patient is only waiting for the provider or the medical assistant to suggest that a payment be made. When it is known in advance that the patient requires extensive treatment, the matter of payment should be discussed early in the course of treatment, the credit policy should be explained, and some agreement should be reached on a payment plan.

Because medical services are far more intangible than any commercial service, collection efforts must not be delayed too long. Any responsible, sincere patient will call the provider’s office after receiving a second statement and explain the delay in payment or ask for a payment plan. This is best accomplished in a private, personal interview.

If the account ultimately must be referred to a collector, find a good agency with a high recovery rate. The value of medical accounts diminishes in direct proportion to the length of time that has elapsed since service was provided. All collection activity is costly. Know when to stop and call on the services of a professional agency.

Special Collection Situations

Tracing “Skips”

When a patient account statement is returned marked “Moved—no forwarding address,” you may consider this account a “skip.” This generally is accepted as an indication that the patient is attempting to avoid liability for debts, although some skips are innocent errors. The patient may have been careless in not leaving a forwarding address, or the mistake may have occurred in the healthcare facility. However, immediate action should be taken with regard to returned patient account statements. Do not wait until the next billing cycle to attempt to trace the debtor.

The Internet can be a valuable tool in tracing skips. You can use the online white pages to search for the patient’s name. Patients might even be found on social networking sites, such as Facebook, and that information may provide clues about the person’s whereabouts. Investigate the search results carefully so that collection efforts are directed at the right person. If all attempts fail, turn the account over to a collection agency without delay. Do not keep a skip account too long because as time passes, the trail may become so cold that even collection experts will be unable to follow it.

Suggestions for Tracing skips

- Examine the patient’s original office registration card.
- Call the telephone number listed in the patient account record. Occasionally a patient may move without leaving a forwarding address but will transfer the old telephone number.
- If you are unable to contact the individual by telephone, make a few discreet calls to the references listed on the registration card to get leads.
- Check the Internet to secure the names and telephone numbers of neighbors or the landlord and contact these people to secure information about the debtor’s whereabouts.
- Do not inform a third party that the patient owes money. Simply state that you are trying to locate or verify the location of the individual.
- Check the guarantor’s place of employment for information. If the person is a specialist in his or her field of work, the local union or similar organizations may be contacted. Although they may not give you the person’s current address, they will relay the message that you are seeking to contact him or her. Often people are stirred to pay if they think their employer may learn of their payment failure.
- Do not communicate with a third party more than once. This is specifically forbidden by law (Public Law 95-109, Sec. 804) unless the third party requests the collector to do so.

Claims Against Estates

The patient account record of a deceased patient may be handled a little differently from regular bills. Courtesy dictates that a bill not be sent during the initial period of bereavement, but do not delay longer than 30 days. The executor will expect to receive the statements from all healthcare providers. Use the following format to address the statement:

- Estate of (name of patient)
- c/o (spouse or next of kin, if known)
- Patient’s last known address

Do not address the statement to a relative unless you have a signed agreement that that person will be financially responsible. If for some reason the statement cannot be addressed as just suggested (e.g., if the patient was in an assisted-living facility or a skilled nursing facility and no relative’s name is available), seek information from the county where the estate is being settled.

A will generally is filed within 30 days of a death. The name of the executor usually can be obtained by sending a request to the Probate Department of the Superior Court, County Recorder’s Office, in the county where the decedent lived. The time limits for filing an estate claim are determined by the state where the decedent resided.

After the name of the administrator or executor of the estate has been obtained, send a duplicate itemized statement of the account.
to that person by certified mail, return receipt requested. If no response is received in 10 days, contact the executor or the county clerk where the estate is being settled and obtain forms for filing a claim against the estate. This claim against the estate must be made within a certain time, which varies from 2 to 36 months, depending on the state where it is filed.

The executor of the estate either accepts or rejects the claim, and if it is accepted, sends an acknowledgment of the debt. Payment often is delayed because of the legal complications involved in settling an estate, but if the claim has been accepted, the provider eventually receives the payment. If the claim is rejected and there is full justification for claiming the bill, file a claim against the executor according to state laws. The time limit in such cases starts with the date on the letter of rejection sent in response to the original claim.

Because states have different time limits and statutes with regard to these issues, the medical assistant should contact the provider's attorney or the local court for the exact procedure to follow; or, the provider may prefer to turn such matters over to his or her legal counsel immediately.

Bankruptcy
Bankruptcy laws were passed to secure equal distribution of the assets of an individual among the individual's creditors. These are federal laws that apply in all the states. When notified that a patient has declared bankruptcy, do not send statements or make any attempt to collect on the account from the patient.

Chapter 7 bankruptcy usually is a "no asset" situation. Because the provider's charges are considered an unsecured debt, there is little purpose in pursuing collection. Chapter 13 is known as wage-earner bankruptcy, which means that the patient-debtor pays to a trustee a fixed amount agreed upon by the court. This money is passed on to the creditors. During this period, none of the creditors can attach the debtor's wages or otherwise attempt to collect the debt. However, the debts are paid in order, secured debts first; consequently, the provider may never receive payment from a debtor who has filed bankruptcy.

Using a Collection Agency
The medical assistant should try every means possible to collect on accounts before they become delinquent. As soon as the account is determined uncollectible through the office (i.e., the patient has failed to respond to the final letter or has failed to fulfill a second promise on payment), the provider should send the account to the collector. Skips should be assigned immediately.

Even though collection by an agency means sacrificing 40% to 60% of the amount owed, further delay only reduces the chances of recovery by the professional collector. If the agency finds that the case deserves special consideration, it will ask the provider's advice before proceeding further.

The collection agency chosen represents the healthcare practice. Therefore, the practice should ensure that its patients are treated with as much respect and dignity as possible through the collection process. There are many different collection agencies, so if one doesn't work out, prepare to switch to another that can better represent the healthcare practice.

CRITICAL THINKING APPLICATION
Brenda has had several complaints about the collection agency used by the office. Patients have called to report that the collectors are threatening and unprofessional. The collection agency's supervisor has been disrespectful to patients and has said that because they owe the money, the collection agency's job is to collect the account in whatever way necessary. How should the healthcare facility approach the collection agency about these complaints?

Working With the Collection Agency
A collection agency needs certain data to enable it to begin collection procedures on overdue accounts:

- Full name of the guarantor
- Name of the spouse
- Last known address
- Full amount of the debt
- Date of the last entry on account
- Occupation of the debtor
- Employer address and phone number

After an account has been released to a collection agency, the healthcare facility can make no further collection attempts. Once the agency has begun its work, a number of guidelines and procedures should be followed:

- Send no more patient account statements.
- The patient account record should be closed for activity because the account was forwarded to a collection agency.
- Refer the patient to the collection agency if he or she contacts the office about the account.
- Promptly report any payments made directly to your office to the collection agency and pay the collection agency's fee.
- Call the agency if any information is obtained that will be of value in tracing or collecting the account.

Making the Decision to Sue
The provider must decide whether he or she will benefit or suffer loss of good will by suing for a balance due rather than writing it off as a loss. Some providers believe it is unwise to resort to the court to collect medical bills unless extraordinary circumstances apply.

An account must be considered a 100% loss to the provider before legal proceedings are started. Remember never to threaten to begin legal proceedings unless the provider is prepared to carry out the threat and has decided to pursue legal action. If the provider decides in favor of a lawsuit, investigate thoroughly and obtain as much information as possible for the proceedings. Litigation to collect a balance due generally is in order when the following are true:

- The patient can afford to pay without hardship.
- The provider can produce office records that support the bill.
- The provider can justify the amount of the bill by comparing it with fee practices in the community.
- The patient's general condition after treatment is satisfactory.
- The persuasive powers of an ethical collection agency have been exhausted, and the agency advises suing.
- The patient can be given ample warning of the provider's intention to sue.
• The defendant (whether a patient or a parent or legal guardian) is legally liable for the services rendered to the patient.
• The statute of limitations has ruled out any possible malpractice action.
• The provider is neither indignant nor in a negative frame of mind.

Small Claims Court
Many healthcare practices find small claims court a satisfactory, inexpensive means of collecting delinquent accounts. The state law places a limit on the amount of debt for which relief may be sought in small claims court; this limit should be checked in local courts before recovery is sought in this manner.

Parties to small claims actions are not represented by an attorney at the hearing but may send another person to court on their behalf to produce records supporting the claim. Providers often send their medical assistant with records of unpaid accounts to show the judge.

If the court awards a judgment for the amount owed, the plaintiff in small claims court may also recover the costs of the suit. For a very small investment in time and money, the provider who uses this method saves the time of a civil court action and eliminates attorneys’ fees.

After being awarded a judgment, the healthcare practice must still collect the money. The only person in a small claims action who has the right of appeal is the defendant. An appeal by the defendant may have the judgment set aside. The plaintiff cannot file an appeal in a small claims action; the decision of the court is final.

The necessary papers for filing action and full instructions on the course to follow may be obtained from the clerk of the local small claims court. It would be wise for a medical assistant who has never appeared in court to attend once as a spectator to preview the procedure; this should allow him or her to feel more at ease when appearing for the provider.

A collection agency to which an account may have been assigned may not file or handle a small claims action. It must either sue in a very small investment in time and money, the provider who uses this method saves the time of a civil court action and eliminates attorneys’ fees.

Posting Collection Agency Transactions
Collection agencies charge the healthcare practice different percentages of the amount owed to collect delinquent accounts; the agency with the cheapest fee is rarely the most effective. Agencies pay the net back, which is the amount of money paid to the practice after the agency has been paid its fee. The net back is the figure that should be considered when a collection agency is used, not simply the fee percentage. If a patient sends a payment after the account has been turned over to a collection agency, the payment must be recorded in the patient account record. Because the agency charges a fee for their collection efforts, the amount sent to the healthcare facility might be less than the actual payment amount. For instance, if the agency charges 25%, a $100 payment results in a $75 payment to the healthcare facility and the agency keeps $25. When posting the payment, the patient account must credit the full amount paid to the collection agency. This would be done by posting a $75 payment and $25 adjustment.

MANAGING FUNDS IN THE HEALTHCARE FACILITY
As mentioned previously, the purpose of financial management is to ensure that the healthcare facility earns enough money to cover its operating expenses. The financial records of the healthcare facility should show the following at all times:

• How much money was earned in a given period
• How much money was collected
• How much money is owed
• The distribution of all operational expenses

An accountant hired by the healthcare facility can prepare monthly and annual financial records from daily bookkeeping records. Periodic analyses of financial resources result in improved business practices, improved time management, elimination of unprofitable services, and more efficient expense budgeting. For the medical assistant, it is crucial to understand the difference between accounts receivable and accounts payable.

Accounts Receivable (A/R)
Accounts receivable is money that is expected but has not yet been received. The amount charged on the encounter form becomes the account receivable for the healthcare facility. When the payment on the patient account record is made, the received payment becomes cash on hand.

To disclose any discrepancies between the balance in all patient accounts and the current account receivable balance, a trial balance should be performed monthly, using the following computation:

\[
\begin{align*}
\text{Accounts receivable at first of month} & \quad \$\phantom{0} \\
\text{Plus total charges for month} & \quad \$\phantom{0} \\
\text{Subtotal} & \quad \$\phantom{0} \\
\text{Less total payments for month} & \quad \$\phantom{0} \\
\text{Subtotal} & \quad \$\phantom{0} \\
\text{Less total adjustments for month} & \quad \$\phantom{0} \\
\text{Accounts receivable at end of month} & \quad \$\phantom{0}
\end{align*}
\]
The end of the month accounts receivable figure must agree with the figure arrived at by adding all the patient account balances. The accounts are then said to be in balance. If the two totals do not agree, this discrepancy should be brought to the attention of the accountant for resolution.

Accounts Payable (A/P)
Accounts payable is the management of debt incurred and not yet paid. All invoices, statements, and operational expenses are included in accounts payable. When expenses have been paid, they are no longer categorized as accounts payable.

Invoices and Statements
If delivered products are not paid for at the time of purchase, the vendor usually includes an invoice for payment with delivery of the merchandise. An invoice describes the products delivered and shows the amount due. Always check to verify that the items listed on the packing slip and invoice are included in the delivery.

Invoices should be placed in a designated accounts payable folder until paid. The healthcare facility may make more than one purchase from the same vendor during the month and send only a single payment at the end of the month for all deliveries.

Paying for Purchases
At the time of payment, compare the statement with the invoice to verify its accuracy. Then, fasten the statement and invoice together, write the date, the amount paid, and the check number on the statement, and place it in the Paid file.

CRITICAL THINKING APPLICATION 16-6
Brenda does not recall ordering a certain item from the office supply company. However, it was included in her last shipment and was shown on the packing list. How can she determine whether the item was ordered?

CLOSING COMMENTS
Patient accounts management and collections are critical responsibilities in the healthcare facility, and a responsible medical assistant is a great asset in this important area. Always maintain a positive attitude with patients when discussing financial matters. Remember that people who are ill or facing challenges are not always cordial, so they may not respond positively to discussion of their patient account balances. Make every attempt to work with each patient to develop a financial plan for settling the account balance. The healthcare facility works hard to collect every dollar, so effective financial management is essential for practice success.

Patient Education
In some cases patients may not fully appreciate all the costs involved in providing high-quality health care. The medical assistant may need to respectfully educate the patient about the basic costs associated with the services provided by the healthcare facility. Patients may not need a lengthy explanation, but they should be informed that the provider does not set his or her fees arbitrarily. The healthcare facility office is a small business, and like thousands of other small businesses, it should collect enough money to cover its operating expenses.

Legal and Ethical Issues
A patient who has filed for bankruptcy cannot be contacted or billed further. Another legal concern is that a threat to send a patient’s account into collections should not be made unless this is the provider’s intention. Never tell a patient that the provider intends to take action if the provider does not plan to follow through.

Because collection laws vary greatly from state to state, medical assistants should review the statutes pertaining to billing and collecting in the area of the healthcare facility’s address. Develop a strong understanding of what is required of small businesses in collecting fees and billing patients for their financial responsibility. Remember that laws change often, so it is important to update the healthcare facility’s policies on billing and collecting to reflect current statutes.

Professional Behaviors
The medical assistant is responsible for coordinating communication between the patient and the provider about financial issues. Some patients may act belligerently toward or try to bully the medical assistant in an effort to reduce their financial obligation. Be sure to inform the patient that the provider’s decision about the patient’s financial responsibility is not based on the medical assistant’s discretion. Also, explain that the medical assistant represents the provider in his or her financial decision making. If the patient’s behavior is out of control, politely excuse yourself and consult with the office manager. Inform the manager of all the details of the encounter, including the healthcare provider’s instructions regarding the patient’s account. The more information you give the office manager, the better able he or she will be to represent you in discussing the matter with the patient. During the entire encounter, remember to remain professional and treat the patient with respect, even though that respect may not be reciprocated.

SUMMARY OF SCENARIO
Brenda has learned much about the different types of bookkeeping transactions performed daily in the healthcare facility. She is never hesitant to confer with Mr. Schmidt, the CPA, whenever she has a question about how to post a transaction in the patient account record. As she gains more experience, she appreciates the important role of patient accounts collection in their practice’s cash flow and their ability to cover its operating expenses.

Dr. Wilkins follows a conservative philosophy when it comes to accounts payable, which enables her to manage her finances wisely. As a result, Dr. Wilkins can provide job security to her best employees, including Brenda.
SUMMARY OF LEARNING OBJECTIVES

1. Define, spell, and pronounce the terms listed in the vocabulary.
   Spelling and pronouncing bookkeeping terms correctly reinforce the medical assistant’s credibility. Knowing the definitions of these terms promotes confidence in communication with patients and co-workers.

2. Define bookkeeping and all of the different transactions recorded in patient accounts.
   Bookkeeping is the recording of financial transactions in the patient account records. Charges, payments, and adjustments can all be recorded in patient accounts.

3. Do the following related to patient accounts records:
   - List the necessary data elements in patient accounts records.
     Patient account records should include all information pertinent to collecting the account, such as the name and address of the guarantor, insurance identification, home and business telephone numbers, name of employer, any special instructions for billing, and emergency or alternative contact information.
   - Discuss a pegboard (manual bookkeeping) system.
     Although we live in a tech-savvy world, many providers still use a manual pegboard system. There are advantages and disadvantages in using a manual bookkeeping system.
   - Explain when transactions are recorded in the patient account.
     Once the provider has entered the procedures into the electronic encounter form, the medical assistant reviews the encounter form and enters the charges into the patient account record.
   - Perform accounts receivable procedures for patient accounts, including charges, payments, and adjustments.
     Practice management software systems automatically calculate the correct fees or charges when a CPT/HCPCS code is entered (see Procedure 16-1). All insurance payment amounts posted should also match the total amount paid on the Explanation of Benefits (EOB). The patient account record should have a column for the adjustment to be posted as a credit (Procedure 16-2).

4. Describe special bookkeeping procedures for patient account records, including credit balances, third-party payments, and refunds; explain how to interact professionally with third-party representatives.
   A credit balance occurs when a patient has paid in advance or an overpayment or duplicate payment is made. Third-party payments are reimbursement payments made from an insurance company that provides benefits for the patient. Refunds are made to insurance companies for overpayments made on patient accounts.
   Some tips for interacting professionally with third-party representatives include (1) before dialing provider services, have all documents readily accessible to discuss the patient account, and (2) when the health insurance representative comes on the phone, refrain from telling him or her how long the wait was; the representatives usually don’t have much control over wait times.

5. Discuss payment at the time of service, and give an example of displaying sensitivity when requesting payment for services rendered.
   The medical assistant must believe that the provider and the facility have a right to charge for the services provided. Do not be embarrassed to ask for payment for the valuable services the clinician provides. When tact and good judgment are used in billing and collecting, patients appreciate the service they receive and the help the medical assistant provides. Give each patient individual attention and personal consideration; also, be courteous and show a sincere desire to help the patient with financial problems.

6. Describe the impact of the Truth in Lending Act on collections policies for patient accounts.
   If credit options are offered for patients, the healthcare facility should be in compliance with Regulation Z of the Truth in Lending Act (TILA). If an agreement exists between provider and patient that the healthcare facility will accept full payment in more than four installments, the healthcare facility must provide a Federal Truth in Lending Statement, even if no finance fees are charged, and it should be signed by the healthcare facility representative and the patient.

7. Discuss ways to obtain credit information, and explain patient billing and payment options.
   Credit information is confidential and should be guarded carefully. Healthcare facilities usually send patient account statements for payment in cycles, which allows a consistent flow of income to the office. A section of patient accounts is billed either weekly or biweekly, and patients send in their payments by mail, bring them in personally, or use an online payment system. Payment is usually requested at the time of service, especially if the patient uses a managed care system that requires a copayment. Medicare Advance Beneficiary Notices provide an option for patients to pay the provider’s fee schedule in full to receive services that Medicare does not cover. Minors cannot be held financially responsible for a bill unless they are emancipated, and the medical profession traditionally has accepted the responsibility of providing occasional medical care for those unable to pay for services rendered. Problems can arise when a provider begins to reduce his or her fees.

8. Review policies and procedures for collecting outstanding balances.
   Most of today’s healthcare facilities use statements from their practice management software to prompt patients to pay overdue bills. Often a message can be added to monthly statements that are increasingly more urgent, depending on the age of the account. Outstanding balances are also collected using telephone calls, e-mails, and personal discussions with the patient or guarantor. More advance collection methods must be used, under the provider’s supervision, if the patient account balance goes without payment. Providers may take special circumstances into consideration (e.g., patient financial hardship) in deciding whether to assign a patient account to collection.
9. Do the following related to collection procedures:
   - Describe successful collection techniques for patient accounts.
     The medical assistant can use a variety of techniques to collect patient accounts, such as collection phone calls, collection letters, and skip tracing. Often more than one technique must be used to obtain payment. Always be courteous and kind when using collection techniques.
   - Discuss strategies for collecting outstanding balances through personal finance interviews.
     Personal finance interviews with patients sometimes can be more effective than a whole series of collection letters. By speaking with a patient face to face, the medical assistant can come to an understanding of the problem more quickly, and an agreement about future payment plans can be reached.
   - Describe types of adjustments made to patient accounts, including nonsufficient checks (NSF) and collection agency transactions.
     With a check drawn on an account with insufficient funds, the bank returns the check to the healthcare facility marked “NSF” and charges the healthcare facility bank account a returned check fee. The payment posted to the patient account must be reversed. Note that the originally payment is not deleted; rather, a charge line item is added with the amount of the NSF check; the transaction description should read “NSF Date 02/23/20-”. Many medical offices add additional line items for NSF fee charges, but this is up to the discretion of the provider. Because collection agencies charge a fee for their collection efforts, the amount credited to the patient’s account might be less than the actual payment amount.

10. Define bookkeeping terms, including accounts receivable and accounts payable.
    Accounts receivable is money that is expected but has not yet been received. The amount charged on the encounter form becomes the account receivable for the healthcare facility. Accounts payable is the management of debt incurred and not yet paid. All invoices, statements, and operational expenses are included in accounts payable. Once expenses have been paid, they are no longer categorized as accounts payable.

11. Discuss patient education, in addition to legal and ethical issues, related to patient accounts, collections, and practice management.
    Patient accounts management and collections are critical responsibilities in the healthcare facility, and a responsible medical assistant is a great asset in this important area. The medical assistant may need to respectfully educate a patient about various things related to payment. Medical assistants should always review their state’s statutes pertaining to billing and collecting.