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COLLEGE OF PHYSICIANS
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STANDARDS OF PRACTICE

Charging Fees

Commented [CD1]: Title changed to avoid unintended narrowing of application.

Under Review: Yes
Issued By: Council: January 1, 2010 (*Charging for Uninsured Medical Services*)
Reissued by Council: September 9, 2014 (*Charging for Uninsured Professional Services*)

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The ***Standards of Practice*** of the College of Physicians & Surgeons of Alberta ("CPSA") are the **minimum** standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the *Health Professions Act* and will be referenced in the management of complaints and in discipline hearings. CPSA also provides **Advice to the Profession** to support the implementation of the Standards of Practice.

PREAMBLE

The *Canada Health Act* and the *Alberta Health Care Insurance Act* (AHCIA) provide the legislative framework for the payment of insured health services in Alberta. This standard addresses circumstances in which regulated members may charge patients or third parties for services and products that are not publicly funded and insured under the Alberta Health Care Insurance Plan (AHCIP).

This standard establishes expectations respecting financial disclosures, patient agreements, billing practices, documentation and invoicing related to non-Plan services. Regardless of whether the transaction involves a service, product or both, regulated members must place the interests of their patients ahead of their own, ensure patients or third parties understand any associated costs before proceeding and be able to justify charges in accordance with professional and ethical obligations.

Where professional services are provided under the dual practice framework as non-Plan services, and patients or a third-party insurer are billed directly, regulated members must also comply with the *Dual Practice* standard.

Related standards and companion resources can be found at the end of this document.

DEFINITIONS

Block fees: fixed fees for all designated services that are not insured under the AHCIP provided during a specified timeframe (e.g., twelve (12) months).

Insured health service: a medically required service provided by a physician, except any service that is excluded under that Act.

Non-Plan services: an insured health service that is provided outside the Alberta Health Care Insurance Plan and is not paid for as an insured health service under the Plan.

Commented [CD2]: In development: link will be added.

Commented [CD3]: Added to address dual billing framework and associated requirements.

Commented [CD4]: Changed to align with new legislative definition.

Commented [CD5]: Added to align with new legislative definition.

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STANDARD

1. In all situations where a patient requires emergency medical care and/or when no other healthcare provider is reasonably available, a regulated member **must** provide care as clinically required, even if the collection of fees may not be possible.

2. A regulated member **must not** charge for:

   a. the provision of insured health services (including the constituent elements of insured health services);

   b. services not performed;

   c. an undertaking to be available to provide services to a patient;

   d. services for which payment is provided under the AHCIP; or

   e. any additional billing on top of what AHCIP has paid or will pay.

3. Amounts charged to patients or third parties for services or products that are not publicly funded or insured under the AHCIP, including block fees, **must:**

   a. reasonably reflect professional and administrative costs; and

   b. be up to date and available on request.

4. A regulated member **may** delegate the provision of preliminary information about fees and billing policies, but the regulated member remains ultimately responsible for ensuring the information is provided to the patient or third party.

   a. A general notice to patients in a regulated member's office is **not** sufficient by itself to fulfill these requirements.

5. Prior to providing a service for which a fee will be charged, a regulated member **must:**

   a. discuss the professional fees with the patient or third party; and

   b. where a service is provided as a non-Plan service, obtain the patient's written acknowledgement that they:

Commented [CD6]: Added for clarity.

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i. have received the required disclosures;

ii. agree to receive the uninsured professional services; and

iii. agree to pay the amount charged.

6. A regulated member who provides professional services for which fees will be charged **must**:

   a. consider the patient's ability to pay, including the possibility of waiving or reducing a fee on compassionate grounds;

   b. make decisions and provide explanations in response to patient requests for accommodation, fee disputes or requests for clarification;

   c. maintain clear documentation in support of all fees charged; and

   d. provide the patient or third party with a detailed invoice that:

      i. identifies each service, product, block fee or other charge;

      ii. identifies the fee charged for each item;

      iii. identifies any additional fees or charges;

      iv. identifies payments received; and

      v. identifies the outstanding balance or confirms the account has been paid in full.

7. A regulated member **must not** charge a patient for being available to provide care or insured after-hours access required by the *Continuity of Care* standard of practice.

Combining insured health & non-Plan services

8. In situations where insured health and non-Plan services are proposed or provided, a regulated member **must**:

   a. clearly communicate to patients which services are publicly funded, and which require payment by the patient;

Commented [CD8]: Added to align with dual practice framework.

Commented [CD9]: Aligns with *Dual Practice* standard/regulations.

Commented [CD10]: From the *Code of Ethics & Professionalism* and CPSBC's *Charging for Uninsured Services* practice standard.

Commented [CD11]: Added to ensure clear, appropriate invoices are provided to patient: supports *Dual Practice* standard.

Commented [CD12]: Clarifies existing block fee clause.

Commented [CD13]: Section added to clarify/answer frequently asked questions – from CPSBC and CPSO's uninsured services documents.

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b. describe the patient's options in a clear and impartial manner, providing unbiased information about the options available, including insured health services and non-Plan services, where applicable; and

c. place the interests of the patient above their own by managing conflicts of interest in accordance with the *Conflict of Interest* standard of practice.

Commented [CD14]: Added to acknowledge dual practice requirements.

Block fees

Commented [CD15]: Section updated to clarify/answer frequently asked questions – from CPSBC, CPSNB, and CPSO's uninsured services documents.

9. A regulated member **may**, but is not required to, offer a block fee payment option to patients on an annual basis for services that are not insured under the AHCIP. A regulated member who offers a block fee option **must** ensure:

   a. the patient understands that payment of a block fee is optional, and they may choose to pay for services that are not insured under the AHCIP as they are provided;

   b. the patient understands that their ability to access healthcare or the quality of care provided will not be affected if they choose not to pay block fees;

   c. the block fee agreement covers a period of no more than twelve (12) months;

   d. the agreement accurately and clearly shows, in writing:

      i. the services that are included in the block fee;

      ii. those that are not included; and

      iii. the fees for each service if paid for on an individual basis;

   e. the patient has the opportunity to ask questions to determine whether block fees are in their best interest;

   f. the patient's written confirmation is obtained if the block fee is chosen and retained as part of the patient's record;

   g. a copy of the agreement, with a copy of this standard, is given to the patient, including the opportunity to rescind the decision to pay a block fee within one (1) week of their original decision;

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i. if the patient does rescind their decision, any amount paid **must** be refunded before then charging the patient individually for any associated services that have already been provided; and

h. patients retain their choice of paying the annual fee or being billed on an individual item by item basis at the end of each agreement.

10. A regulated member who offers a block fee option **must not**:

a. promise, imply or provide preferential services to patients who pay block fees;

b. charge a block fee to cover administrative or overhead costs associated with providing insured health services;

c. require a patient to pay the block fee before accessing insured health services;

d. terminate or refuse to accept a new patient because the individual chooses not to pay a block fee; or

e. include in a block fee any service for which the regulated member is compensated through any other means.

Charging for missed or cancelled appointments

Commented [CD16]: Section added to clarify/answer frequently asked questions – from CPSBC, CPSNB, and CPSO's uninsured services documents.

11. A regulated member **may**, but is not required to, charge for appointments that are missed or cancelled with less than twenty-four (24) hours' notice.

12. A regulated member who charges for missed or cancelled appointments **must**:

a. have evidence that:

i. the patient was informed of the policy on missed appointments, including the amount of the charge and how much notice must be provided, prior to any charges being billed; and

ii. the patient failed to provide at least 24 hours' notice of the cancellation;

b. have a twenty-four (24) hour messaging service (e.g., answering service, answering machine, voicemail, etc.) by which the patient can advise of their inability to keep their appointment;

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i. such service must be accessible both during and after regular office hours;

c. have been available to the patient at the intended appointment time and otherwise unable to provide services to another patient during that period;

d. ensure charges reasonably reflect the actual costs incurred; and

e. take into account the circumstances of the missed appointment, exercising judgement and compassion when considering the patient's ability to pay.

13. A regulated member who charges for missed or cancelled appointments **must not** refuse subsequent care in the presence of an outstanding invoice.

a. Recurrent failure to keep appointments **may** be grounds for termination in accordance with the *Terminating the Physician-Patient Relationship* standard of practice.

Collecting fees

Commented [CD17]: Added for clarity - from CPSO's uninsured services policy.

14. A regulated member may take action to collect any outstanding fees owed to them but **must** do so in a manner that is professional and in accordance with privacy legislation.

15. A regulated member who uses a third party to administer and/or manage block fees or payments for services that are not insured under the AHCIP **must** ensure that:

a. any communication between the third party and patients identifies the third party by name and indicates they are acting on the regulated member's behalf; and

b. the third party adheres to the same privacy standards required of regulated members, including this standard, other relevant CPSA standards and relevant legislation.

ACKNOWLEDGEMENTS
CPSA acknowledges the work of the Colleges of Physicians and Surgeons of British Columbia, Ontario and New Brunswick in preparing this document.

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RELATED STANDARDS OF PRACTICE

- *Code of Ethics and Professionalism*
- *Continuity of Care*
- *Dual Practice*
- *Establishing the Physician-Patient Relationship*
- *Informed Consent*
- *Patient Record Content*
- *Practicing Outside of Established Conventional Medicine*
- *Responding to Third Party Requests*
- *Responsibility for a Medical Practice*
- *Terminating the Physician-Patient Relationship*

COMPANION RESOURCES

- Advice to the Profession:
  - Charging Fees [to be updated]
  - Continuity of Care
  - Ending the Physician-Patient Relationship
  - Establishing the Physician-Patient Relationship
  - Informed Consent for Adults
  - Informed Consent for Minors
  - Insured Persons
  - Physicians as Custodians of Patient Records
  - Practicing Outside of Established Conventional Medicine
  - Responsibility for a Medical Practice
- Advice to Albertans:
  - Ending the Physician-Patient Relationship
  - Establishing the Physician-Patient Relationship
- AMA's Uninsured services

AH's Health care services covered in Alberta

- Canadian Medical Protective Association:
  - Medical Letters, Forms, and Reports
  - Responding to a Patient Without a Health Card

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REFERENCES

- CMA's *Code of Ethics & Professionalism* (2018).
- CPSBC's *Charging for Insured Services* Practice Standard (Apr. 2026).
- CPSO's *Uninsured Services: Billing and Block Fees* Policy (Nov. 2004).
- CPSNB's *Charging for Uninsured Services* Professional Standard (Apr.2021).

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