FINANCIAL POLICIES AND PROCEDURES

At [Name of Practice], we believe that all patients who are rendered care at this office deserve the best medical care that can be provided. For us to provide you with the highest quality medical care and current technology, we must ensure that we are able to meet the expenses necessary to operate this facility. To ensure that these expenses are met, we provide you with this Agreement regarding our financial policy and your agreement to pay for services provided. Please sign and date this Agreement on the last page to indicate you accept these terms.

PAYMENT AT TIME OF SERVICE, FEES AND COLLECTIONS

Your insurance policy is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance carrier. We do provide your insurance carrier with information regarding your diagnosis and treatment. We do not get involved in such matters as disputes regarding deductibles, copayments, non-covered charges and "usual and customary" charges. If your insurance carrier does not provide payment within 40-60 days after treatment, you will be responsible for payment. You are responsible for timely payment on your account. We require that you pay any amount not covered by your insurance such as deductibles and copayments under your policy on the day of service. If your plan requires you to pay co-insurance, you will be required to pay that. [Name of Practice], is required in accordance with its contract with your insurer to collect from you deductibles and copayments. We will determine your copay and how much of your yearly deductible under your policy has been met for the year. If you are unable to pay your copayment at check-in, another appointment will be made for you. Any additional payment owed will be collected in full at the time of service. If needed, we will work with you to arrange a payment plan.

We will request to see your current insurance card and photo identification at every visit so that we may bill the insurance company in a timely fashion. It is your responsibility to ensure we receive current and valid insurance coverage at each visit. It will be reviewed or copied every time you are here for a visit, no matter how frequently you are seen. If a claim is rejected because your insurance does not cover the type of service rendered, you will be held responsible for the outstanding balance. **Please call the telephone number on your insurance card before your appointment and they will assist you in finding out whether the service to be provided at the appointment is covered, whether a referral or prior authorization is required, and what your copay is and what your deductible is.** It is your responsibility to understand your insurance coverage. If your insurance does not cover the cost of your visit or procedure, you will be responsible for the charges for all services rendered.

Please educate yourself as to your coverage so that office visits, procedures, testing, and specialist referrals may be arranged to best suit your needs.

Once we determine your personal financial obligation or after your insurance company reimburses [Name of Practice], for a portion of your care, we may mail you one (1) statement. Payment is expected upon receipt of the statement. Any account past due by 30 days or more may be subject to submission to our collection agency. If your account becomes delinquent and is placed into our collection process, collection fees will be your responsibility and added to your balance. [Name of Practice], reserves the right to discharge any patient at this point. By signing our financial policy, you agree to pay these added fees, along with all costs associated with the collection of your account, including interest charges.

If a new problem is encountered, or if changes in treatment of a pre-existing condition are discussed in the process of performing a visit or exam, an additional copay and deductible payment may be incurred.

If you are seen in our office by a nurse or a medical assistant for minor medical services you may be charged a limited office visit, and applicable co-pays will be collected.

If you carry a balance on your account during the time you present at our office, a payment on your account will be required at the time unless a Credit Card is kept on file or a payment plan is in place. [Name of Practice], reserves the right to terminate any patient who misses a payment. Under unusual circumstances, we are willing to work out personalized payment schedules if you so require and can demonstrate need. We accept cash, check or credit card.

COPAYS AND DEDUCTIBLES

Copays and deductibles may be required by your insurance and plan. This is a contract between you and your insurance. We also have contracts with your insurance, and we are required to collect these at each visit. We will not waive any copay or deductible, so please do not ask us to. Failure to pay these at the time of service will result in your appointment being rescheduled.

REQUIRED PATIENT HEALTH INUSURANCE POLICY OR SUMMARY PLAN DESCRIPTION

Insurance companies must provide you with a copy of your health insurance policy and a Summary Plan Description (SPD) at the time of your policy being effective and/or at annual renewal time. This is required by federal law. Your insurance policy is an agreement between you, your employer (if your employer sponsors your health insurance) and the insurance company. Your employer is required to ensure the insurance company follows the policy requirements properly as they are the fiduciary of your policy (if your employer sponsors your plan). ***You are required to provide us a copy of your policy on an annual basis so we can ensure that services that are covered under your policy and plan are delivered and paid for properly by your insurance company.*** They cannot require prior authorizations or delay services or payment on your services whenever they want. They have to follow the rules. If we have your policy or SPD on hand, we can assist you in assuring your insurance company allows you to obtain services communicated in your policy.

CREDIT/DEBIT CARD ON FILE

We have wonderful patients and we know that most of your pay your financial obligations. Unfortunately, this is not the case with all patients. You will no longer receive bills from our office in the mail. We require a credit or debit card on file with our office. Statements are wasteful of paper, stamps, and envelopes and are not efficient. We need to ensure that we have a guarantee of payment on file in our office. Times are changing in healthcare, and we need to be sure that patient responsible balances are paid in a timely manner. We must be fair and apply the policy to all patients. We have wonderful patients and we know that most of you pay your balances. Unfortunately, this is not the case every time.

You will receive a letter in the mail from your Insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits, or EOB. This letter tells you exactly, according to your health insurance coverage, how much of your health care bill is your responsibility and how much is the responsibility of your insurance to pay. We receive the same letter that you do. It arrives about 20 – 30 days after your appointment. We look at each Explanation of Benefits (EOB) carefully and determine what your insurance has determined as patient responsibility. This is the same way we normally determine how much to send you a bill for in the mail.

We do not store your sensitive credit card information in our office. We store it in a secure fashion with a reputable financial firm called a gateway. We access your information only on this site to process a payment. You will be required to sign a credit card on file authorization statement that will allow us to charge an amount agreeable to each of us until your balance is paid in full.

We will always work with you to understand if there has been a mistake, and we will refund you if we have made a billing error. We will only charge the amount that we are instructed to by your insurance carrier, in the letter they send to us and the amount that you have agreed to, in the same way that we normally determine how much to send you a bill for in the mail.

ELECTIVE PROCEDURES/NON-COVERED PROCEDURES/NO SURPRISES ACT

Patients are required to pay the estimated self-pay portion of elective/non-covered procedures prior to services being rendered based on insurance verification and eligibility of benefits.

In keeping with Federal Regulations regarding items not covered by your insurer (The No Surprises Act), we will endeavor to provide you with a good faith estimate of what the charges will be for a certain service, which are due and payable prior to the service being rendered. If the service, when provided, turns out to be a higher cost than what was estimated, we will provide you with an explanation for the additional costs. Sometimes, additional services are needed during procedures that we are not aware of at the time of developing the estimate because of a change in diagnosis, etc. That additional cost will be due and payable upon receipt of notification from our office.

SUBMISSION OF CLAIMS

We will submit your insurance claims. However, it is important to remember that your insurance is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services regardless of the amount your insurance pays.

PAYMENT OPTIONS

Our office accepts most credit and debit cards. Our office also accepts valid check or cash. There will be a $50 fee for all returned checks. Once we have a returned check for you, we may require that all future payments be with cash, money order, cashier's check or credit card. Anytime a co-pay, deductible or balance is due, we will charge the fee to your credit card which will help to keep you at a zero balance and paid up in full with your credit card on file.

CASH PAYMENT

If you wish to pay cash, you will always be provided with a receipt so that you will have a record of your payment. Please make us aware if you are not provided a receipt.

INTEREST ON LATE PAYMENT

All account balances are expected to be paid upon receipt of statement or within sixty (60) days of the date of service or invoice amount will be drafted from ACH account or charged to credit card unless other arrangements have been agreed to. Account balances in excess of sixty (60) days will incur interest of one and one-half percent (1.5%) per month or eighteen (18) percent annually.

MEDICAL DEBT

A holder of any medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

MEDICARE PATIENTS

If you have Medicare as your primary insurance carrier, but you do not have a secondary insurance, you are responsible for the deductible, copay, and co-insurance at the time of service. You are also responsible to pay for services not covered by your Medicare insurance unless you have a secondary insurance. You will be required to sign an Advanced Beneficiary Notice for non-covered services.

NON-CONTRACTED INSURANCE (Out of Network)

If you have an insurance plan that we do not participate with, you may or may not have out-of-network benefits. These benefits typically have a higher copay, coinsurance, and/or deductible out of pocket cost. You will be considered a self-pay, uninsured patient if you do NOT have out of network benefits and if your insurance does not pay for the service, you are financially responsible. Please understand that what your non-contracted insurance deems "allowable" may not cover the entire charge and you would be responsible for any difference.

UNINSURED/SELF-PAY

We offer a discount to all self-pay patients who pay in full at time of service. Payment is expected at each visit. All other ancillary, treatment and future care will be reviewed with you in order to make arrangements for payment. We require a $100 non-refundable deposit to be placed with us to schedule your first visit with us which will then be used toward the total cost of your first visit or applied to as payment towards your co-pay and the balance left will be credited or returned to you, whichever you prefer. If you fail to show up for your visit, this will be determined as payment for not showing up for your appointment.

MISSED APPOINTMENTS/NO SHOWS/LATE FOR APPOINTMENT

We understand that you may not be able to keep all your scheduled appointments or might occasionally be late. Please understand that missed appointments have a detrimental impact on our practice and other patients. They also affect our ability to serve other patients in need of medical care. We understand there may be inclement weather or other circumstances that may require you to cancel your appointment. If you must cancel or re-schedule your appointment, please do so at least 24 hours in advance. Failure to cancel or reschedule an appointment at least 24 hours in advance will be considered a no-show. We reserve the right to charge you $150.00 for any no-show if permitted by law and your insurance contract. Payment of the missed appointment will be required prior to scheduling another appointment. [Name of Practice], reserves the right to terminate any patient with more than two no-show appointments upon 30 days written notice to the patient to seek medical help from another practice.

If you are running late on the day of your appointment due to unforeseen circumstances, please contact our office immediately so that we can determine whether we can see you that day or if we will need to reschedule your appointment. If you are more than 15 minutes late for an appointment, [Name of Practice], may reschedule your appointment and refuse to see you at the originally scheduled time.

REFERRALS

If your insurance carrier requires a referral or authorization for your visit, it is your responsibility to make sure that our office receives current valid authorization. If you do not have a valid referral or authorization at the time of service, we will be unable to treat you until a valid authorization/referral is obtained, and you may be sent back to your primary care physician to obtain authorization prior to being treated or full payment will be expected at the time of service. Please remember that it is your responsibility to make sure we are on your plan's provider listing. We appreciate your understanding of the ever-changing requirements of managed care plans and our position to adhere to their policies or requirements.

FORMS AND MEDICAL RECORDS FEES

Due to the increasing costs of providing our patients with the highest standards of care, we must impose a charge for certain records and forms. It takes time for our providers and staff to retrieve and copy files, complete forms and write letters. The following charges apply:

FMLA, Disability, Corps, School forms not completed during an appointment, and Supplemental insurance forms $50.00 per page.

Dictated letters, extensive forms with review of medical records $50.00 per page

Copies of records for personal use will be charged the current allowed fee by the [Name of State or Commonwealth].

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize [Name of Practice]: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for all services provided to me by [Name of Practice]. This order will remain in effect until revoked by me in writing.

I have received the practice's Medical Authorization for Release / Disclosure of Protected Health Information / HIPAA Privacy Notice.

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby authorize as the beneficiary/participant of a health care plan governed by the Employee Retirement Income Security Act (hereinafter, ERISA) and the Patient Protection and Affordable Care Act (hereinafter, PPACA) do hereby appoint and specifically designate [Name of Practice], to act as my AUTHORIZED REPRESENTATIVE pursuant to C.F.R. §2560.503–1(b)(4).

I hereby authorize and instruct my ERISA plan administrator and/or fiduciary, and/or ERISA insurer, to release to such AUTHORIZED REPRESENTATIVE any and all plan documents, insurance policy or policies upon written request from such AUTHORIZED REPESENTATIVE in order to claim such medical benefits, reimbursement or any applicable remedies.

I hereby convey to the above named AUTHORIZED REPRESENTATIVE, to the full extent permissible under the law, including but not limited to, any ERISA claim for benefits, breach of ERISA fiduciary duty, and ERISA claim for statutory penalties for failure to produce documents or information in accordance with ERISA §502(a)(1)(B), §502(a)(3) and §502(c)(1)(B), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received or was prescribed, and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies including, but not limited to, (1) obtaining information about the claim to the same extent as the beneficiary; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such AUTHORIZED REPRESENTATIVE to pursue such claim, chose in action or right against any liable party, party-in-interest, or employee group health plan(s), including, if necessary, funding and authority to bring suit by such AUTHORIZED REPRESENTATIVE against any such liable party, party-in-interest, or ERISA employee group health plan, in my name.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents,

summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

Unless revoked, this APPOINTMENT OF ERISA and PPACA AUTHORIZED REPRESENTATIVE is valid for all administrative and judicial reviews under ERISA and PPACA, and/or any applicable federal or state laws. **A photocopy of this Appointment of ERISA Authorized Representative is to be considered as valid as the original.**

I HAVE READ, AGREE WITH, AND FULLY UNDERSTAND THIS AGREEMENT.

______________________________ _____________________

Beneficiary/Participate Signature Date Appointed
Patient Name (PRINT):

______________________________ _____________________

Signature Date
Name of Person Financially
Responsible for Patient's
Treatment (PRINT):

I, ____________________________________ agree to be appointed and designated as the aforementioned **HIPAA Authorized Representative**, as requested by the above named Beneficiary/Participant, effective as of the date appointed by the aforementioned Beneficiary/Participant. My name and address is as follows:

Name: ____

Address: ____

City: __________________________________ State: ___________________ Zip Code: __________