

Office Financial Policy

Patient Name: _____ Date of Birth: ____/____/____

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Medicare:

We are Medicare participating provider. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of:

- a. The annual deductibles
- b. Copayments
- c. Charges for noncovered or cosmetic services*

* You will be asked to sign an Advanced Notice of Liability Form in the event that a service is provided which we know is not covered by Medicare.

If you have Medicare, as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.

Non-Medicare/Commercial Plans:

If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of:

- a. The annual deductibles
- b. Copayments
- c. Charges for noncovered or cosmetic services*

In the event that you, as the patient, or we, as the physicians, are not aware of a charge that is not covered by your plan, you will be billed the balance after we obtain a denial from your insurance carrier.

For non-Medicare patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship, please note the following:

- a. We will file both your primary and secondary insurance. If we do not receive payment from your primary carrier within 45 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.
- b. If we receive payment from the primary, we will file a claim with your secondary. If we do not receive payment from your secondary carrier within 45 days of filing, you will be billed for the remaining amount. Payment is due 10 days after receipt of the statement.
- c. If you only have primary insurance (e.g., no secondary/supplemental coverage), you will be asked to prepay 50% of the entire bill. Any amount not paid by your insurance company will be billed to you. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. The entire balance remaining after your primary carrier has paid will be billed to you and is due and payable 10 days after receipt of the statement.

Returned Checks and Delinquent Accounts:

There will be a \$30.00 charge on all returned checks. If your account becomes delinquent and must be placed with a collection agency, you will be responsible for all costs of collection. Timely payment will prevent consequences to your credit rating.

I have read and understand my financial responsibilities under this policy.

Patient or Parent's Signature (If under 19 Years of Age) _____ DATE _____

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone _____

May we leave personal medical information on your answering machine at home? Yes ___ No ___
If no can we leave a call back number only? Yes ___ No ___

Cell Telephone _____

May we leave personal medical information on your voicemail on your cell? Yes ___ No ___
If no can we leave a call back number only? Yes ___ No ___

Written Communication

O.K. to mail to home address

Do you give our office permission to discuss your medical information with family members?

YES NO If yes, please provide their name and phone number.

Name: _____ Relationship: _____

Phone# (day): (____) _____ Evening # (____) _____

Patient or Parent's Signature if under 19 years of Age

Date

Print Patient Name

Patient's Date of Birth

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent

This Consent was signed by: _____
Printed Name - Patient Name

Date: ____ / ____ / ____
Signature/Parent if under 19 Years of Age

Relationship to Patient
(if other than patient): _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____