The Center for Family Medicine
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Privacy Practices Notice

By signing this authorization form, **I agree that I was offered** a copy of the privacy practice notice of The Center for Family Medicine. The notice describes the intended use and disclosures of my private health information (defined in the 1996 Privacy Ruling of HIPAA along with the updated rules, which went into effect march 26, 2013). I understand that by signing this document I can at any time have the right to revoke, inspect and receive copies of any and all of my private health information.

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Assignment and releases, I hereby authorize my insurance benefits to be paid directly to The Center for Family Medicine. I understand I am financially responsible for any portion of my bill not covered by insurance; this may include remaining balances, co-payments, co-insurance, deductibles and non-covered services.

I authorize The Center for Family Medicine to release to my insurance carrier or its designated agents any information concerning my medical care (physical and/or psychological), advice, treatment or supplies provided to me for the purpose of administration, review, investigation or evaluation of claim coverage and utilization of services. I authorize that a copy of this information to be as valid as the original. I will notify the Center for Family Medicine in writing of any information I do not want released.

8. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. Kindly give 24 hours notice when canceling/rescheduling your appointment as a courtesy to our other patients as we try to provide same day appointments. **After three missed appointments without providing 24-hour notice, you will be charged a $50 fee.**

10. **Workman's Compensation Policy.** I understand that I am responsible for payment in full at the time of services unless authorization for treatment has been obtained prior to services being rendered. It is my responsibility to submit all claims for reimbursement.

11. **Text messaging**. If information is shared in that format I am aware that text messages are generally **not** secure because they lack encryption, and the sender does not know with certainty the message is received by the intended recipient. Also, the telecommunication vendor/wireless carrier may store the text messages. Any information shared may become part of the medical record and I do so at **my own risk**.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

Persons you would like to have <u>access to your records</u>::

<u>Print Name(s)</u> **<u>Relationship</u>**

- _____ _____
- _____ _____
- _____ _____