

Avance Care: Disclosures and Consents

Patients or legal guardians for minor child MUST sign and date all paragraphs below before medical care can be rendered.

PATIENT INFORMATION

Legal Name: (First) (Middle) (Last)

Date of Birth:

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Avance Care, P.A., or the providers individually, for services rendered to my dependents or to me by the physician or a clinician under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-payments, co-insurance, deductibles or balances due that are my responsibility for payment either at the time of service or after being notified that Avance Care, P.A. is unable to collect from my insurance carrier for whatever reason.

FINANCIAL RESPONSIBILITY:

I certify that I have received, read and understood a copy of the Avance Care Patient Financial. I also understand that I am ultimately responsible for the charges incurred by me or by my child/children as their legal parent or guardian. Therefore, knowing this, I request that services be performed and I agree to be responsible for any charges incurred. I understand that if I fail to make payment when due and my account becomes delinquent or is turned over to a collection agency or attorney for collections, that I undersigned shall pay all collection agency fees, court costs and attorney fees, and risk being dismissed from the physician care of Avance Care, P.A.

For Self-Pay patients, I also understand that I am responsible for all services rendered to my dependents or myself at the time of service.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Avance Care, P.A. or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of Avance Care Notice of Privacy Practices. I hereby authorize Avance Care, P.A. or the physician individually to release any of mine or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls and e-mail. I hereby authorize the Avance Care, P.A. representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Avance Care, P.A. to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services from another facility. I further understand that I am financially responsible for any co-payment, co-insurance, deductible or balance due for these services if they are not reimbursed by my insurance for whatever reason.

ADDITIONAL FEES FOR EXTENDED HOURS SERVICE:

I understand that Avance Care, P.A. may charge additional fees (not to exceed \$50) to help compensate for higher operating costs for visits during evenings (after 6PM), weekends, and holidays. This fee is added to the baseline charges for the visit.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing and treatment for me or my dependents as directed by my physician/physician-extender or his or her designee at Avance Care. I understand the services may include lab tests, screening tests, diagnostic tests, and routine exams. I understand that no promises have been made to me about the results of any treatment or services.

PATIENT SIGNATURE: _____

(or Legal Guardian, for minor patient)

DATE: _____

PRINT NAME: _____

GUARANTOR SIGNATURE: _____

(If different from patient)

DATE: _____

GUARANTOR NAME: _____

AVANCE CARE: Patient Financial Agreement

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your financial responsibility.

FULL PAYMENT OF PATIENT OBLIGATIONS IS DUE AT TIME OF SERVICE.

We accept: Cash, Checks and Credit Cards

- ✓ Always bring your current health insurance card to the office.
- ✓ Please notify us at time of check-in of any changes in insurance, address, telephone or family status.
- ✓ Please pay your co-pay or deductible balance and co-insurance amount at the time of service.
- ✓ You will be expected to pay in full if:
 - You do not have insurance,
 - Avance Care does not participate with your health plan,
 - You are unable to present a valid member identification card from your insurance carrier at your visit, or
 - We are unable to verify your insurance coverage.

You should receive a bill for any other patient responsibility within 30 days; and/or an explanation of benefits (EOB or EOP) from your insurance company. If you fail to receive an EOB or EOP from your plan within 45 days of treatment, we suggest you contact your insurance plan to determine benefits, as they may not have made payment. Payment not received in 60 days may be transitioned to patient responsibility and you may be required to make other payment arrangements.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits please be aware that some, and perhaps all, of the services provided may be non-covered services under your plan and you will be 100% responsible for these charges. It is your responsibility to:

- Ensure our providers actively participate with your insurance carrier.
- Know your benefit coverage, as well as your dependents, prior to receiving services.
- Ensure that all pre-approval requirements are met to avoid denials or out-of-network benefits.

Please remember that we must receive your billing information at the time of each visit in order to meet claims submission guidelines set by your insurance plan. If either the practice or the plan fails to receive accurate information to process your claim, you will be held responsible.

We will not be held liable for ensuring the accuracy of your insurance information, including, but not limited to verifying current coverage and eligibility, obtaining authorizations, or confirming co-pay, coinsurance, and/or deductible information. Regarding Insurance Plans where we are a participating provider, all co-pays and deductibles are due at time of treatment. In the event that your insurance coverage relates to a plan where we are not a participating provider, you will be 100% responsible for all charges incurred.

To summarize, your financial responsibility retains to:

- Denied and Non-covered services
- Services deemed not medically necessary by your insurance company
- Co-payments, deductibles, co-insurance
- Pended claims due to lack of patient and/or guarantor information
- Non-Insurance and/or out-of-network benefits

CO-PAY, COINSURANCE: We are required by our insurance contracts to collect all co-pays and other patient responsible amounts, at the time of service. We may request a deposit – prior to be seen by the physician – of \$25.

CO-PAY SURCHARGE: Any co-pays that are not paid on the day of the visit will be subject to a \$10.00 co-pay processing fee. To assist you, we accept cash, checks or credit cards.

DEDUCTIBLES: If you have not met your deductible – we will estimate the expected insurance payment for your visit and request that amount at check-out – this is an estimate only – you may receive a statement with additional balances after your visit. We may also request a deposit – prior to be seen by the physician of \$75.

SELF-PAY PATIENTS: Self-Pay patients are required to make a deposit of \$75 at the time of service during check-in. If additional charges are accrued, you must pay by the charges before leaving the office.

RETURNED CHECKS: There is a fee (currently \$25.00) for any checks returned by the bank. This amount may change.

MISSED APPOINTMENTS: Unless canceled at least 24 hours in advance, our policy is to charge \$35.00 for missed appointments. There may be an additional fee for missed physicals. We will not file, nor will insurance plans pay for this charge, so please help us serve you better by keeping, or canceling in advance, scheduled appointments.

AFTER HOURS TELEPHONE CONSULTATION: You may be charged a \$25.00 fee for providing medical advice during non-business hours.

COLLECTIONS: Failure to pay account balance within 30 days from initial billing may result in interest charges up to maximum legal amount allowed by law and handling fee of \$10. Any past due balance not paid will be turned over to a collection agency after 90 days. Any charges and fees resulting from this action, including collecting agency fees, will be added to your account balances and will be your responsibility. In the event that the bill remains unpaid and litigation ensues for collection of sums due, this office shall be entitled to reasonable attorney fees and court cost.

LAB/X-RAY/DIAGNOSTIC SERVICES: You may receive a separate bill for medical care includes lab, x-ray, or other diagnostic services from another facility. You are financially responsible for any co-pay or balance due for these services if they are not reimbursed by your insurance.

STATEMENTS: If you have a balance on your account, we will send you a statement. It will show separately the previous balance, any new charges to the account, and any payment or credits applied to your account during the month.

PAYMENTS: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within ten (10) days.

PAYMENT OPTIONS IF YOU HAVE NO INSURANCE: Unless arrangements are made in advance, we will collect payment at your visit. Your choice is to pay by cash, check, or credit/debit card on the day that treatment is given.

INSURANCE RELEASE: You understand that your health plan may not be liable for service rendered if any of the following conditions apply:

- You have a pre-existing condition or other diagnosis that may not be covered by your plan;
- Avance Care does not participate in your health plan;
- You have not met the deductible under your health plan contract;
- Well child check-up, immunizations, adult or sports physicals, as well as other routine services, may not be covered by some insurance plans.

DIVORCE: In case of divorce or separation, the parent authorizing treatment for child/children will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

ON-THE-JOB INJURIES/ACCIDENTS: If the reason for your visit is an accident or injury while on the job, please know that we will submit the bill directly to your employer or your employer's workers' compensation carrier – *the bill will not be covered unless your employer files a claim to the carrier* – it will remain your responsibility until a valid claim is filed by your employer.

COPIES AND TRANSFER OF RECORDS: All past due amounts will be collected before medical records are copied or transferred. A nominal fee is assessed to cover copy costs.

EFFECTIVE DATES: Once you have signed this agreement, you agree to all of the terms and conditions contained herein for this and any future visits, and the agreement will be in full force and effect.

Patient Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____