Disclosures and Consents

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

Patient Name:____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 dependent(s) 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.

MEDICARE 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 provider on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received, read, and have access to a copy of Avance Care Notice of Privacy Practices by their website or in the office. I hereby authorize Avance Care, P.A. or the provider 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 provider to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, laboratory results, or financial information regarding my services, including insurance claims. 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.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing and treatment for me or my dependent(s) 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.

CONSENT TO RETRIEVE PRESCRIPTION HISTORY:
I hereby consent to retrieval of my prescription history from external sources such as SureScripts network. This information is used to ensure the safety and accuracy of your prescription service and to coordinate care with other providers.

I have read and acknowledge the content of this Disclosures and Consents notice above ________ (Initial)

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

O I DO NOT want my health information be shared with anyone. My refusal will not affect my ability to obtain healthcare treatment or payment or eligibility for benefits.

O I DO want my health information shared as specified below. This authorization will expire in two years from today. I have the right to revoke this authorization at any time by stating this in writing and sending my written revocation to Avance Care, P.A.

I authorize Avance Care, P.A. to release protected health information to the entities below:

Give information to spouse/partner: O Yes O No Name of spouse/partner: ____________________________

Give information to a parent (if above 18), friend or family member, please list:

Name:____ Relationship to Patient:_____________________________

Name:____ Relationship to Patient:_____________________________

Description of Information to be released:
Financial/Billing: O Yes O No Please list any restrictions:____

Medical Information: O Yes O No Please list any restrictions:____

Patient Financial Agreement

The following is an agreement between the patient, or responsible party, and Avance Care, P.A. 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.

You agree to:

- Full payment of my obligation is due at the time of service.
- Always bring your current health insurance card to the office.
- Always notify us at the time of check-in of any changes in insurance, address, telephone or family status; we will not be held responsible for incurred late fees/collection fees.
- Pay your co-pay or deductible balance or deposit 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,
  - 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 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 pertains 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 or coordination of benefits
- Non-Insurance and/or out-of-network benefits

Should you choose to not use your insurance and do not want your claims filed to your insurance provider this must be told to the front desk before your appointment in order to take your insurance information out of our system. If not informed, a claim will automatically be billed out to your insurance company. Patients who do not wish their insurance to be billed must pay in full for all services rendered at the time of service. Avance Care is unable adjust claims that have already been billed to the patient's insurance and placed towards patient's responsibility.

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 be happy to provide treatment, but we do not participate in Workman's Compensation insurance, and you are ultimately responsible for all charges. You will be asked to pay for these services up front, and Avance Care, P.A. will provide you with a detailed receipt upon request in case you choose to file to your insurance carrier personally.

I have read, understood, and agree to all of the terms and conditions contained herein _________ (Initial)

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 provider.

DEDUCTIBLES: If you have not met your deductible or if you have a high deductible plan we may also request a deposit, prior to seeing a provider at a minimum $100.

SELF-PAY PATIENTS: Self-Pay patients are required to make a deposit of $150 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 cancelled 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 cancelling in advance, scheduled appointments.

AFTER HOURS TELEPHONE CONSULTATION: You may be charged a $50.00 fee for providing medical advice during non-business hours.

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.

BALANCE LATE FEE: Any co-pays, deductibles, co-insurances, non-covered, or self-pay charges that are not paid on the day of the visit will be subject to a $20.00 late fee. To assist you we accept cash, credit cards, or CareCredit®.

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 late fee of $20. Any past due balance not paid will be turned over to a collection agency after 90 days. 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, the undersigned, shall pay all collection agency fees, court costs and attorney fees, and risk being dismissed from Avance Care, P.A.

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

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.

I have read, understood, and agree to all of the terms and conditions contained herein _________ (Initial)

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 understand that Avance Care uses one of these outside labs at its locations: Quest Diagnostics and LabCorp (“Outside Lab”). I understand that outside Labs are not associated with Avance Care. I am not obligated to use the Outside Lab at my location of service and can use other labs in the area. I understand that it is my responsibility to check with my insurance company to see if Outside Lab or other facility where I receive x-ray or other diagnostic service is covered under my plan. I further understand that, I am financially responsible for any co-payment, co-insurance, deductible or other balance due for these services if they are not reimbursed by my insurance for whatever reason.

ADDITIONAL FEES FOR EXTENDED HOURS SERVICE:
In order to help compensate for our higher operating costs during evenings (starting at 6 PM), weekends, and holidays, Avance Care uses Extended Hours Service specialty code while submitting insurance claims on your behalf. The fee for this service code is up to $50. This fee is added to the baseline charges for your visit. Most insurance companies recognize this billable charge and will provide full or partial reimbursement. You may be responsible for only the insurance’s negotiated charge in the event that your insurance company assigns it to your deductible or coinsurance.

For Self-Pay, there is a $15 charge for all visits occurring on weekends or evenings (starting after 6 PM) to the baseline of all charges.

I have read, understood, and agree to all of the terms and conditions contained herein _________ (Initial)

I have read and acknowledge the content of this Disclosures and Consents notice, and Patient Financial Agreement.

PATIENT SIGNATURE: ______________________________________ **DATE**: ________________________
(or Legal Guardian, for minor patient)

LEGAL GUARDIAN NAME: ____ **RELATIONSHIP**:___________________