BEEBE MEDICAL GROUP, INC.

FINANCIAL POLICY / ASSIGNMENT OF BENEFITS / AUTHORIZATION to TREAT

Payment Policy: Thank you for choosing us as your health 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. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage and benefits.
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 non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. If you are insured by Medicare, an ABN (Advanced Beneficiary Notice) will be obtained.
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 or photo ID along with a copy of your current health insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of your claim.
5. **Claim submission:** We will submit your claims and assist you in any way reasonable to assist in the claim process. 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 and we are not party to that contract.
6. **Coverage changes:** If your insurance changes, please notify us before your next visit so we may 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. It is important that we notify you of non-payment so we may assist you in the claim process. Several insurance companies have imposed timely filing deadlines that possibly could impact payment on your account. Some deadlines are as early as 60 days from the date the services were rendered.
7. **Non-payment:** If your account is over 90 days past due, you will receive a letter stating that you have 15 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.
8. **Missed appointments:** Our policy is to charge **$35.00** for missed office visits not canceled 24 hours prior to the appointment time. Likewise, you will be charged **$35.00** for missed testing appointments. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

NOTICE OF PRIVACY CONSENT

Notice of Privacy: I understand that I have been provided the Notice of Privacy Practice that provides more complete information of uses and disclosures. I understand I have the right to review the notice before signing this consent. I understand that I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment or health care operations and the organization is not required to agree to the restrictions requested. I understand I have the right to revoke this consent in writing, except to the extent that the organization has already taken action on my behalf.

ASSIGNMENT OF BENEFITS

Assignment of Benefits: For those health care providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those health care providers who have rendered services to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default.

Medicare Lifetime Beneficiary Claim Authorization and Release of Information: I request that payment of authorized medical benefits be made either to me or on my behalf to Beebe Medical Group for any services furnished to me by the physician. I authorize any holder of medical information about me to release to Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services.

I understand my signature requests that payment be made and I authorize release of medical information necessary to pay the claim. If other health insurance is indicated on the claim form or electronically submitted claim, my signature authorizes release of information to the insurer. In Medicare assignment cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Authorization to Treat: Permission is hereby granted to all health care providers involved in my care to administer such examination, treatment, testing and procedures that are deemed necessary in the course of my care.

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

______________________________ _____/___/____ ______________________________________ ___/___/____

Patient Signature **Date** **Patient Name (Print)** **Date of Birth**

__________________________________ ____

Authorized Representative Signature **Authorized Representative (Print)/Relationship:**

□ Legal Guardian □ Spouse □ Parent □ Adult Child □ Adult Brother/Sister □ Grandparent

□ Adult Grandchild □ Unrelated Caregiver □ Power of Attorney (POA) □ Other ______________________

Obtained verbal consent from Parent or Guardian – Date ________________ Time ________________