Financial Policy, Consent and HIPAA Acknowledgement

Patient Name:

Today's Date: 05/12/22

- **Insurance Billing**- I consent for the practice to bill my insurance company according to the most recent insurance information and insurance card(s) including, Medicare and Medicaid Advantage Plan cards, that I have provided. I understand that all payment of all balances is my responsibility, including co-pays, co-insurance amounts, deductible amounts and services that are not covered by my insurance plan (such as cosmetic services). I understand that if claims are denied due to lack of current insurance information, I will be responsible for the balance.
- **Insurance Network-** I understand that it is my responsibility to ensure that this practice and the provider of services are in my insurance network and to obtain any referrals or authorizations required by insurance plan. If my claim is denied because I am out of network or failed to obtain a referral or authorization, I understand that I will be responsible for the balance.
- **Good Faith Estimates-** If I am uninsured, or if I request that covered services not be billed to insurance, I understand that I may request a Good Faith Estimate of the total fees that I may be charged and that fees for all services must be paid on the date that services are rendered.
- **Past Due Balances-** I understand that if my account is over 90 days past due, this practice will send a statement and I will have 20 days in which to pay the balance in full. Partial payments will not be accepted unless previously negotiated. I understand that if the balance remains unpaid this practice may refer my account to a collection agency and/or I may be dismissed from this practice.
- **Rescheduling Policy-**I am aware that if I am late to my appointment I may be rescheduled. I also understand that multiple missed appointments without adequate notice and/or late arrivals may result in my dismissal from the practice. This practice may assess a fee for missed appointments.
- **Prescription History-** I authorize this practice to request prescription history information electronically from my local pharmacy(ies) for the purpose of providing direct health care services unless otherwise revoked.
- **HIPAA Disclosure-** I consent for this practice to release information to my insurance company, primary care/referring physician, and any other covered entities in accordance with the HIPAA Privacy Act. I understand that medical information disclosed will be used and forwarded in order to provide continuing treatment or care, for filing claims, and for all other healthcare operations only. I have been given the opportunity to review this practice's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information. I have the right to review such notice prior to signing this consent form.
- **Disclosure of Information-**I have been given the opportunity to verbally provide my emergency contact information. Additionally, I have verbally given the practice, at my discretion, information on who the practice may share my information by phone. I understand that I am responsible for notifying the practice if there are changes to those that may participate in my care.

My signature indicates that I have been given the opportunity to review this information, ask questions and have had my questions answered. I understand that I am financially responsible for all services as described in this consent form.