MaxHealth
Family, Internal & Sports Medicine

FINANCIAL DISCLOSURE AND AGREEMENT

Patient Name: _____ Date of Birth: _____

We feel it is important for our patients to have an understanding of our financial policies and how they may be affected by them. Please ask questions regarding this document before you leave the office today. We are more than happy to assist you!

Please initial next to each section.

_____ (initial) **PROOF OF INSURANCE:**
Your insurance card(s) and a picture ID should be brought to each appointment. It is your responsibility to inform the front desk of any changes in address, phone number or employment and when your insurance plan changes so that the correct plan is billed for your visit. Failure to provide requested information within 30 days of the visit will result in the claim(s) becoming the patient's responsibility. **It is also your responsibility to know what your benefits are and if we are a participating provider on your plan.**

_____ (initial) **CONTRACTED INSURANCE**:
If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a copay, coinsurance or a deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. It is our obligation under many of our contracts to report patients who repeatedly refuse to pay copays, coinsurance and deductibles at the time of service or who repeatedly "no show" for appointments. If you are reported, you could possibly lose your health care benefits. Contact your employer's human resource department for further clarification of your benefits and obligations. If your insurance requires a referral and/or prior authorization, you are responsible for making sure you have that authorization prior to seeing a specialist or seeing MaxHealth as a referred patient by your PCP (e.g. Sport Medicine).

_____ (initial) **NON-CONTRACTED INSURANCE:**
Your insurance is a contract between you and your insurance company. We are not a party to that contract. Using an out-of-network provider will generally result in a greater out of pocket cost. We will bill your primary insurance company as a courtesy to you and you agree to pay any portion of the charges not covered by insurance. If your insurance requires a referral or prior authorization, you are responsible for obtaining it.

_____ (initial) **SECONDARY INSURANCE:**
Our office does not file with secondary insurances unless required by law. If you do not have a government regulated plan, you will be expected to pay your primary insurance's required copay, coinsurance or deductibles at the time of service.

PREVENTIVE WELL EXAMS (physicals, well woman, well child):

NOTE: Preventive Care Services as defined by the Affordable Care Act is care that is focusing on evaluating your current health status when you are symptom free. Preventive care allows you to obtain early diagnosis and treatment, to help avoid more serious health problems. As such insurance allows certain services during the preventive exam and excludes other services.

_____ (initial) **Preventive Care Includes** immunizations, physical exams, lab work and x-rays. During your preventive visit your doctor will determine what tests or health screenings are right for you based on many factors such as your age, gender, overall health status, personal health history and your current health condition.

_____ (initial) **Preventive Care Excludes** medical treatment for specific health conditions, on-going care, lab or other tests necessary to manage or treat a medical issue or health condition are considered diagnostic care or treatment, not preventive care.

_____ (initial) Patients requesting, prior to or during the appointment, Preventive Care & Diagnostic Care/Treatment (e.g. refills on medications) services will be responsible for paying as self pay for the Diagnostic Care/Treatment services. Only the Preventive Care services will be filed to your insurance. Payment for these services is due at the time of your visit; prior to prescriptions being printed or sent to your pharmacy.

_____ (initial) **WORKERS COMPENSATION/ MOTOR VEHICLE ACCIDENTS:**
Please note that we cannot treat for **worker's comp injuries;** contact your employer for further instruction. If you have been involved in a **motor vehicle accident**, we can treat you and, if you choose, file your medical insurance; however, we cannot bill a third party (e.g. auto insurance) for the charges. You will be responsible for payment in full at the time of service and we will provide you with the information necessary to file on your own.

_____ (initial) **PHYSICIAN ASSISTANTS:**
This facility has on staff a physician assistant to assist in the delivery of medical care. A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health

maintenance care. "Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided. It is your right refuse to see the physician assistant and request to schedule with a physician at any time.

_____ (initial) **PAYMENT OPTIONS:**
We accept cash, money orders, personal checks, debit, and credit cards. We *do not* accept temporary or post-dated checks. Checks presented are electronically converted to an ACH debit. There is a $30 fee for all returned checks.

_____ (initial) **REQUIRED PAYMENTS:**
Patients without insurance, as well as those who have insurance but are seen for non-covered services, will be expected to pay in full at the time of service. Copays, coinsurance and deductibles are due at the time of your visit.

FEES:

_____ (initial) ***No Show Fees*** **-**$25 for missed preventive well exams or surgical appointments. $35 for manual therapy or rehabilitation, musculoskeletal procedures, neurotherapy or counseling appointments. $100 for Acuity Brain Center Intake appointments; deposit due at scheduling. $15 for all other types of missed appointments.

_____ (initial) ***Cancellation Without Notice Fees*** **-**$35 for manual therapy or rehabilitation, neurotherapy or counseling appointments. $100 for Acuity Brain Center Intake appointments; deposit due at scheduling.

_____ (initial) ***FMLA or Disability Paperwork*** **-**$25.00 fee per completion. Fees are due at pick-up of the completed paperwork or prior to being electronical submitted to the patient &/or their employer.

_____ (initial) ***Medical Records*** **-**One copy provided per year at no cost. Additional copies: Paper format is $25 for the first twenty pages and $.50 per page thereafter, plus postage. Electronic format is $25 for 500 pages or less; $50 for more than 500 pages, plus postage, if applicable. Patients are able to access & download their medical records via our patient portal at no cost.

_____ (initial) **MONTHLY STATEMENTS:**
If you have a balance on your account, we will send you a monthly statement. Unless other arrangements have been made in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

_____ (initial) **PATIENT RESPONSIBILITY:**
If you receive a bill after your share has been collected at checkout, it could be due to several things, including incorrectly quoted benefits or claim processing by your insurance company. If an explanation of benefits is received from your insurance company showing a difference in patient responsibility than what was collected in our office, we will adjust your account accordingly. Please note that payment at the time of service does not equal payment in full. If you feel your claim may have been processed incorrectly, please call your insurance company.

_____ (initial) **PAST DUE ACCOUNTS**:
If your account becomes past due, we will take necessary steps to collect this debt. If your account is referred to a collection agency, you agree to pay all of the collection costs which are incurred. Failure to meet your financial obligations may also result in termination (upon 30 day notice) from treatment by our doctors.

_____ (initial) **WAIVER OF CONFIDENTIALITY:**
You understand if this account is forwarded to a collection agency and your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

_____ (initial) **DIVORCE:**
In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child 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.

_____ (initial) **EFFECTIVE DATE:**
Once you have signed the acknowledgment for this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

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FINANCIAL DISCLOSURE NOTICE ACKNOWLEDGEMENT

I have read the **Financial Disclosure Notice** provided to me and understand my financial obligations. I agree to pay the amounts required of me for any fees or services incurred at ***MaxHealth.*** I am over 18 years of age or I am the parent or guardian of the patient. I give permission for ***MaxHealth*** (Elis Medical Corp.) to bill my insurance (if applicable) and release information to my insurance, if necessary, for payment of claims.

Patient (or guardian) Signature: _____ Date: _____

Print Name: _____ Relationship to Patient if a minor: _____