

Diabetes & Glandular Disease Clinic, P. A. Patient Financial Responsibility Policy and Acknowledgement Form

At Diabetes & Glandular Disease Clinic, P. A. (DGD Clinic, P.A.) the Providers and staff are dedicated to providing the best possible care and service to patients. In order for DGD Clinic, P.A. to continue to provide such care, a patient financial responsibility policy has been adopted by DGD Clinic, P.A. and provided for patients to obtain a complete understanding in regard to patients' financial responsibilities while obtaining the clinic's care and service.

Payment Due at Time of Service

Patients are required to pay copays, deductibles and or any applicable charges as verified by insurance or private pay fees at the time that care and services are rendered.

Accepted Forms of Payment

DGD Clinic, P.A. currently accepts payment in the form of cash, valid check and credit card (VISA, MasterCard and Discover). For checks written by the patient that are returned for NSF reasons, there is a \$30.00 fee. DGD Clinic, P.A. does not accept personal checks dated in advance and reserves the right to collect full amount due before further treatment can be provided.

Refusal or Unable to provide full payment due at time of care or service

If the patient refuses or is not able to pay payment in full for applicable co-pays, deductibles, fees or balances due as reflected in insurance plans and or patient's account at the time of arrival for scheduled appointment, DGD Clinic, P.A. reserves the right to reschedule the patient appointment until payment in full can be made.

Accepted Insurance

DGD Clinic, P.A. has made arrangements with insurers and health plans to accept an assignment of benefits (Arrangement defined as DGD Clinic, P.A. will bill plans for which an agreement is in effect and will require patient to pay the applicable copayments and any co insurance fees due at the time of service). A list of insurance plans accepted by DGD Clinic, P.A. can be obtained upon request.

If applicable and current patient accepted insurance information is not provided to DGD Clinic, P.A. and/or the insurance provided by the patient is not able to be verified prior to the billing deadline, DGD Clinic, P.A. reserves the right to request the full payment from the patient at the time of service rendered.

Diabetes & Glandular Disease Clinic, P. A. Patient Financial Responsibility Policy and Acknowledgement Form

Private Pay/Out of Pocket Payment (cash payment)

If the patient has insurance coverage with a plan which DGD Clinic, P.A. does not have an agreement in effect with or the patient requests to pay for services or care obtained out of pocket via cash, DGD Clinic, P.A. provides fair and affordable fees for patients that pay out of pocket (cash) and are considered private pay patients for services or care rendered. Please inquire from a staff member to obtain current private pay fees. Such charges are due in full at the time of service by the patient.

Services or Care “not covered” by Patient Accepted Insurance Plan

In the event that the patient has an insurance plan that determines a service billed to be “not covered”, “ineligible” or “rejected” for payment to DGD Clinic, P.A.; the patient will be responsible to pay in full the negotiated rate established and provided by the patient insurance carrier for the service and care rendered.

Remaining Balance or Denial of Services or Care Rendered by Patient Insurance

If the patient responsibility has a remaining balance or if the claim is denied by the insurance company after services are rendered, DGD Clinic, P.A. will send a statement with the current balance due to the patient address on file that provides payment information to the patient to include due date, payment options and clinic contact information.

Accepted Patient Insurance Required Referrals

If the patient insurance plan requires a **referral** from the Patient Primary Care (PCP) physician, the patient is responsible to contact the PCP for the referral. Obtaining the referral is the patient’s responsibility as the PCP may require documents that the patient must review and acknowledge to obtain a referral prior to sending referral to DGD Clinic, P.A. Note: Although it is not the responsibility of DGD Clinic, P.A., DGD Clinic, P.A. can provide guidance to the patient to obtain the referral as required by the insurance company to prevent delay in obtaining DGD Clinic, P.A. services and or care.

Required Referrals Not obtained or provided by Patient or Primary Care Physician at time of service or care rendered

If the patient requests that DGD Clinic, P.A. provide care and or treatment without the referral required by patient insurance, DGD Clinic, P.A. will consider this the patient consent for the care or treatment without obtaining required referral. The patient acknowledges the care or treatment provided during applicable visit will not be covered by insurance and the patient will provide accepted form of payment for all applicable fees at the time of care or service.

Diabetes & Glandular Disease Clinic, P. A. Patient Financial Responsibility Policy and Acknowledgement Form

Scheduling Appointments with Balance Due

Patients with an outstanding balance of 60 days or more overdue or amounts considered “high” from prior services or care rendered must pay outstanding balance in full or make arrangements for payment to be paid in full by working with staff prior to scheduling additional appointments.

Hospital Care Cost

DGD Clinic, P.A. will bill patient insurance plan for all services provided in the hospital. Any services provided not covered, paid by insurance plan or balance due is the patient responsibility and should be paid as instructed in statement provided to patient from DGD Clinic, P.A.

Refunds

Patient /guarantor refunds in amounts of \$20.00 or less will be reflected on patient account to be used as credit toward future balances. For amounts of \$20.00 or less to be paid to patient in form of payment provided can be requested by the patient/guarantor with a written request to DGD Clinic, P.A. Amounts over \$20.00 will be refunded to the patient /guarantor within 30-45 days of DGD Clinic, P.A. refund reconciliation processing by assigned DGD Clinic, P.A. staff. If there is further delay in processing the refund as stated, DGD Clinic, P.A. will notify the patient/guarantor and provide a timeline to expect refund payment.

Minor Patients

Minors patients are required to be accompanied by an adult regardless of status or relationship to minor patient. DGD Clinic, P.A. will look to the adult accompanying the minor patient for payment due at the time of services rendered. If payment is not obtained, all policies as stated above will be applicable.

Termination of Patient Care

Patient termination of care may be considered by DGD Clinic, P.A. if the outstanding balance is not paid as stated in policy or a payment plan is not established for continuing service or care. In addition, the patient account may be considered to be turned over to a collection agency and/or dependent on the balance due of a claim. DGD Clinic, P. A. may consider and file a claim in small claims court or civil court.

Cancelled or Missed Appointments

Cancellations are required 24 hours prior to the appointment. In the event that you fail to cancel in advance a scheduled appointment a fee may be required to be paid if the staff is not able to reschedule appointment in the time required to

Diabetes & Glandular Disease Clinic, P. A. Patient Financial Responsibility Policy and Acknowledgement Form

receive service or care as directed by provider. Excessive abuse of no show or last minute cancellations of scheduled appointments may result in termination of care by the practice and any outstanding balance is due upon receipt of a statement sent by DGD Clinic, P.A.

Charity Care

In all circumstances, this office is committed to delivering quality medical care. If circumstances qualify patient for Charity Care, please request information from a staff member at DGD Clinic, P.A. to obtain required forms for consideration.

Note: Applying does reflect Charity Care will be automatically granted. Applying is required to be considered to be granted and is granted at the discretion of DGD Clinic, P.A. If such care is granted, the patient will be notified by a staff member at DGD Clinic, P.A. and information will be discussed with patient regarding Charity Care granted.

Diabetes & Glandular Disease Clinic, P. A. Patient Financial Responsibility
Policy and Acknowledgement Form

Authorization to Release Information

I _____ (print full name clearly) hereby authorize Diabetes & Glandular Disease Clinic, P.A. to: (1) release any information necessary to insurance carrier(s) regarding myself or dependents' illness, care and or treatments; (2) process patient insurance claims generated in the course of examination or treatment; and (3) authorize a photocopy of my signature to be used to process patient insurance claims for the period of a lifetime. This authorization will remain in effect until revoked by patient reflected in authorization in writing to DGD Clinic, P.A. for any information.

I _____ (print full name clearly) have requested medical services and or care from Diabetes & Glandular Disease Clinic, P.A. on behalf of myself and/or my dependents and understand that by making this request, I become financially responsible for any and all charges incurred to include past due balances in the course of the services, care or treatment provided by DGD Clinic, P.A. and accepted by patient.

I have read and understand the Diabetes & Glandular Disease Clinic, P.A. Financial Policy. I further understand that applicable fees are due and payable on the date that services and care are rendered and in addition agree to pay any charges in full as instructed in statements provided to patient by DGD Clinic, P. A.

I agree that if it becomes necessary to forward an outstanding balance due reflected in my account to a collection agency that in addition to the balance due, I will be responsible for applicable charges by the collection agency for collection services requested and obtained by DGD Clinic, P.A. A photocopy of this assignment is to be considered as valid as the original. I also understand and agree that DGD Clinic, P.A. may amend such terms from time to time and fully understand/ acknowledge that I may be required to review and acknowledge patient required forms to include this Diabetes & Glandular Disease Clinic, P.A. Patient Financial Responsibility Policy Form on a reoccurring basis due to edits, updates or changes on patient policy forms or as requested by Diabetes & Glandular Disease Clinic, P.A.

Date: _____

Full Printed Name of Patient as reflected on form of Identification

Signature of Insured or Authorized Representative

Diabetes & Glandular Disease Clinic, P. A. Patient Financial Responsibility Policy and Acknowledgement Form

Assignment of Benefits

I _____ (print full patient name clearly) hereby assign all medical benefits, to include major medical benefits to which I am entitled, authorize and direct my insurance carrier(s), including Medicaid, private insurance and any other health/medical plan, to issue payment check(s) directly to Diabetes and Glandular Disease Clinic, P.A., for medical services and or care rendered to myself and/or my dependents reflected on health plans regardless of my insurance benefits. I fully acknowledge and understand that I am responsible for any balance due or not covered by patient insurance provided to DGD Clinic, P.A.

Assistance & Questions

For Patient assistance or questions in reference to the Patient Financial Responsibility Policy please contact a staff member via phone during clinic hours between 8:30 a.m. and 5:00 p.m., Monday through Friday at (210) 614-8612 or by requesting a same day meeting before scheduled appointment time.