FINANCIAL POLICY

Thank you for choosing **Endocrinology Associates P.A.** for your health care. We are committed to providing quality medical care for you. In order to reduce potential misunderstandings, our office has clarified our Financial Policy. We require that you read our Policies and agree to comply with them prior to beginning or continuing treatment, as of September 1st, 2010.

Appointments

Our goal is to provide the best possible care and physician availability to each of our patients**. In order to achieve this,** our policy is to request that you call to cancel **at least** 24 hours prior to **your** scheduled appointment. If you missed your appointment, you will be charged a **$50 no show fee. Both** new and returning patients are subject to the $50 no show fee for missed appointments **that are not cancelled 24 hrs in advance**. A No Show fee will **not** be charged to you if you or a HIPAA compliant family member can provide documentation that you were in the hospital or you were attending a funeral at the time of the appointment.

Our system works as follows: You will receive an appointment reminder call two days prior to your appointment. The automotive TeleVox call will provide you with the option to confirm the appointment, cancel the appointment, or leave a message with a scheduler. If you do not reschedule the appointment, a scheduler will call you. If you missed an appointment, you will receive an automotive TeleVox no show call. It is our policy to send a Letter of Termination of Care to patients with **three cumulative** no show appointments.

Insurance

Your insurance policy is a contract between you and your insurance plan. We cannot efficiently bill your insurance company unless you provide us with current and valid insurance information. We will file claims to those plans with which we have a **contractual** agreement.

All health plans are not the same and they do not always cover the same services or facilities. In the event that your health plan determines that a service is "not covered" you will be responsible for the entire charge. This office is not responsible for disputing decisions made by your insurance carrier regarding coverage. Payment for services rendered is due by the **1st day of the month** after the charge has printed on your statement.

We expect you to familiarize yourself with the benefits and limitations of your insurance policy including, but not limited to: deductible and co-payment amount as well as approved labs, radiology facilities, and hospitals contracted with your plan. It is your responsibility to notify our office when either your insurance plan or benefits change. Any cost incurred by this office because of incorrect information you provided to us will be passed on to you. Balances must be paid in full at the time of the appointment. **Endocrinology Associates P.A.** does not extend credit, offer discounts to patients with contracted insurances, or waive balances.

If you have insurance coverage with a plan with which **Endocrinology Associates P.A.** does not participate, charges for your care and treatment are due at the time of service. **Endocrinology Associates P.A.** does not extend Self Pay status to new patients with out of network insurances.

No Insurance

If you have no insurance coverage **Endocrinology Associates P.A.** has implemented a Self Pay Fee Schedule for those services that are 'Medically Necessary'.

Delinquent Payments
The following types of accounts will be referred to a collection agency:

- Mail returned with no forwarding address.
- Guarantors who refuse to cooperate.
- Guarantors who not do respond to telephone and mail contacts.
- Guarantors who do not make promised payments.
- Balances, that are not paid within 30 days, will incur further collection activity

Deductibles/Copays/Payments
Our insurance contracts require us to collect deductible amounts and copays at the time of service. These amounts will be collected prior to service being rendered. For your convenience we accept VISA, MasterCard, Discover, and American Express in addition to personal checks and cash. If your check is returned to us for insufficient funds, we will assess a service charge equal to the bank fees assessed to **Endocrinology Associates P.A**.

Notice of Privacy (HIPAA)
Endocrinology Associates P.A. originates and maintains health records, describing your health history, symptoms, examinations, test results, diagnosis, treatments, and any plans for further care. This information serves a basis for your care and treatment, as a means of communication among healthcare professionals who contribute to my care, a source of information for applying your diagnosis and surgical information to your bill, a means by which a third-party can verify that services billed were actually provided, and a tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals. Your health records may be disclosed by fax, mail, verbal conveyance, type written, and or electronically transmitted to other healthcare professionals to assist in your care. Examples of information that may be in your chart that are considered private, according to the Health Insurance and Portability Act (HIPAA) are individually identifiable health information (e.g. name, address, date of birth, social security number, etc.). You have the right to ask your physician, directly, for your health information contained in your medical chart. Family and friends may only have access to your health information if you designate them on the Notice of Privacy Practices portion of this form, at the bottom of the last page.

Information
I hereby agree that the enrollment information is correct and I also agree that any changes to the enrollment information will be communicated to **Endocrinology Associates P.A.** as required to fulfill the medical and financial obligation for services rendered.

Authorization
I hereby request and consent that my medical records and non written records be sent to my referring physicians, those physicians or ancillary facilities that I am referred to by the **Endocrinology Associates P.A.** and to my insurance company or its agents that may be authorizing treatment. I further understand that my medical records may contain sensitive information and hereby authorize the release of all confidential HIV related information, communicable diseases related information, drug and alcohol abuse/treatment information and mental health diagnosis/treatment information to the undersigned.

I hereby authorize payment directly to the attending physician for medical and/or surgical benefits, if any from the insurance carrier to **Endocrinology Associates P.A.**; if paying cash, I am responsible to pay at the time of service.

_____ _____

Patient Name (Please print) Date of Birth

_____ _____

Signature of Patient and/or Legal Guardian Date

_____ _____

Endocrinology Associates' Witness Date

I authorize the following person(s) to have access to my medical information.

_____ _____

Relationship

_____ _____

Relationship

I authorize **Endocrinology Associates P.A.** to leave detailed **medical information**, appointment reminder calls and no show calls on the phone number(s) listed below:

Appointment Reminder Call: ( ) No Show Call: ( )