ADVANCED
ADULT CLINIC

FINANCIAL POLICY AGREEEMENT

1. **INSURED PATIENTS -** You are ultimately responsible for knowing your insurance policy coverage. You are responsible for all payment obligations and are expected to provide payment at the time of service. Please present your insurance ID at every visit. Not doing so will cause us to reschedule your appointment. Always update our clinic of any changes in your insurance policy.

Deductible/Co-Insurance: All applicable co-insurance and deductibles are due at the time of service. An estimate will be provided and payment is required before services are rendered. This does not constitute final payment and any additional balance due after the insurance claim is adjudicated will be due upon receipt of a bill.

Co-Payments: Your insurance company requires us to collect co-payments at the time of service. Due to state and federal laws, co-payments will not be waived.

Claims Submission: As a courtesy, we will bill your insurance. A quote of benefits is not a guarantee of payment. We will submit your claims and assist you until claim is resolved. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for full payment. You are responsible for all non- covered services according to your insurance company's guidelines. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred and payment is due upon receipt of the bill. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner. You are responsible to provide a copy of your most recent insurance cards for all applicable health plans. Accounts that are 90 days past due may be referred to a collection agency.

Preventative Care Services: Routine wellness exams may be covered by your insurance. However, when a medical concern or symptom is addressed at the time of your wellness visit, preventive benefits will no longer apply. Additional fees may incur including but not limited to co-pays, deductibles, and co-insurance.

Ancillary Services: Laboratory and outpatient radiology procedures will be billed separately by an outside provider. Please contact them directly with any questions regarding your bill.

Workers' Compensation Cases: Charges for services incurred as a result of a verified work- related injury will be treated as workers' compensation, and we will bill the workers' compensation carrier as a courtesy. You must provide necessary information to bill the carrier. You are responsible for the completion of information with the employer and approval of the workers' compensation claim. In case your workers' compensation claim is denied, you will also provide us with your medical insurance information. If your claim is denied, we will bill your regular medical insurance carrier. When the claim is no longer pending and any portion of your claim is ultimately resolved against you by workers' compensation and your medical insurance, you will be required to pay all amounts due within thirty (30) days.

2. **SELF-PAY PATIENTS -** If you do not have insurance, you will be expected to pay for your entire visit, including the office charges, applicable laboratory fees, and ancillary fees at the time of service. We will request a $150 deposit prior to seeing the physician. If you are unable to do this, your appointment will be rescheduled.

3. **THIRD PARTY LIABILITY INJURIES.** If you receive treatment as a result of a third-party liability injury (for example: motor vehicle accidents, premises liability, or other general liability claims against third parties), the balance for services rendered is considered due in full at the time of the service. Because we do not protect charges incurred

relating to or arising out of third party liability, we will not accept a delay in payment due to settlement disputes and/or litigation. We will not accept a letter of protection from an attorney as a guarantee of payment or assignment of third party insurance payments. We cannot act as administrator to resolve financial arrangements. We may agree to bill a third party insurance company of an at-fault party involved in an accident as a courtesy to you. To bill your claim directly, you must provide us all necessary information to confirm coverage for these payments with the auto/third-party carrier. We will also collect information about your personal medical insurance in case the auto/third-party carrier denies your claim. Regardless of whether we submit your claim to third-party insurance, as the patient, you are ultimately responsible for payment.

4. **Cancellation of appointments** without prior notice or cancellation / rescheduling with less than 24 hours notice will be subject to a $25 dollar fee. Please remember than doing so prevents other patients from being seen by the physician.

5. **Other fees** pertaining to request for medical records and request for completion of forms apply as follows:

- $25.00 Fee - Request to complete Life, Disability, FMLA, & various other types of independent health forms. Please note that an appointment may be required depending on the form and the type(s) of information requested.

- $15.00 clerical processing fee plus $0.25 per page for paper printed request of medical records. Additional postage fee if to be mailed to the patient. If request is via CD, there is a flat fee of $15. Please note that a written request from patient is required prior to release of any record. Please allow 10-14 business days for processing of such request.

6. **Non-Payment on Account.** Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that our clinic has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) all court costs and fees (but only to the extent allowed by law); and (iii) a collection fee to be charged under separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. You acknowledge that any such interest assessed on the account will be a late fee as a result of default or delinquency on your account, and is not deemed interest as part of a credit transaction. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history; and related portions of your account, including the fact that you received treatment at our offices, may become a matter of public record. Failure to comply with any of these policies may also result in a Credit Withdrawal of Care.

7. **Financially Responsible Party.** If this or a separate Advanced Adult Clinic, Inc Financial Responsibility Statement is signed by another person, on your account, then that co-signature remains in effect until cancelled in writing. Cancellation in writing shall become effective the date after receipt, and shall apply only to those services and charges thereafter incurred. By signing as a financially responsible party, you hereby guarantee the full and prompt payment to Advanced Adult Clinic, Inc of all indebtedness of patient to Advanced Adult Clinic, Inc, whether now existing or hereafter created (the “Indebtedness”); and you further agree to pay all expenses, legal or otherwise, incurred by the Advanced Adult Clinic, Inc in collecting the Indebtedness, in enforcing this guaranty, or in protecting its rights under this guaranty or under any other document evidencing or securing any of the Indebtedness. This guaranty shall be a continuing, absolute and unconditional guaranty, and shall remain in force and effect until any and all said Indebtedness shall be fully paid. There shall be no obligation on the part of Advanced Adult Clinic, Inc at any time to first exhaust its remedies against Patient, any other party, or any other rights before enforcing the obligations of the financially responsible party.

8. Accepted modes of payment include cash and all major credit cards (VISA, Mastercard, Discover, American Express). We do not accept checks.

I have read and acknowledged the above financial policies of Advanced Adult Clinic, Inc.

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Name and Signature of Patient or Legal Representative Date

INSURANCE ASSIGNMENT, AUTHORIZATION AND NON-COVERED BENEFITS WAIVER

I hereby assign benefits to be paid directly to Advanced Adult Clinic, Inc and authorize the clinic to furnish information regarding my illness to my insurance carrier. I understand that I am responsible for any amount not paid by insurance. I understand certain tests or procedures are not a covered benefit within my insurance plan or policy. I know that if I have any questions regarding what is or is not covered under my insurance plan or policy, I should contact my insurance carrier prior to having the test/procedure performed. If I have a test or procedure performed that is not a covered benefit within my insurance plan or policy, I understand I am responsible for payment in full for the incurred charges. I understand that Advanced Adult Clinic, Inc will consider this waiver current for today's visit and any future visits, until I provide the clinic with a different payor and /or insurance information.

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Name and Signature of Patient or Legal Representative Date