WEST COAST INFECTIOUS DISEASES

OFFICE FINANCIAL POLICY

PATIENT'S NAME_____ DATE: _____

Welcome to Our Office

Please read this policy carefully and feel free to ask questions regarding any part of this form. We believe that a clear definition of our office and financial policies will allow us to concentrate on the primary goal of taking care of your health. Our WCID strives to provide you with the finest quality care. If you have any questions regarding your treatment, please do not hesitate to ask. We welcome referrals and look forward to establishing a satisfactory doctor-patient relationship.

This financial policy is an agreement between you and West Coast Infectious Diseases, P.A. ("WCID"), as a creditor, and you, as the patient/debtor named on this form. The words "you", "your", and "yours" means the patient/debtor. The word "account" means the account that has been established in your name or the patient's name listed above to which charges are made and payment credited. The words "we", "us", and "our" refer to the West Coast Infectious Diseases, PA.

Appointments: If you are unable to keep an appointment, please call the office to reschedule at least 72 hours in advance. Patients with two missed appointments will be charged a $25.00 no-show fee which is not reimbursable by any insurance. Patients with repeated missed appointments may be dismissed from the WCID. Patients who are more than 15 minutes late may be asked to reschedule.

Transferring Records: Patient's requesting copies of their records are asked to submit a request in writing to include all relevant information, including your payment history **upon request**. Please be aware that our policy is to provide records within 30-days from receipt of request. The fee for copying your records is $1.00 for this first 25 pages, and .25 cents for each additional page. If you are requesting your records to be transferred from another doctor or organization to us, you have to authorize us to receive all relevant information including your payment history.

Assignment: You agree to assign all medical benefits, to include without limitation "major medical" benefits, which your are entitled inclusive of Medicare and all other health care payors to the WCID and its providers. You authorize WCID to file a claim, as a courtesy, for payment with your insurance company and/or Medicare (if applicable) for services provided to the you/patient and you request that payments for such services be made directly to WCID and/or any physician providing services to you/patient, as applicable. If the insurance company fails to pay for any reason, you understand that you will be responsible for prompt payment of all amounts owed to WCID. Payment is due at the time services are provided unless other arrangements have been made actions.

Insurance: Insurance is a contract between you and your insurance company. (We are not a party to this contract, in most cases). We will bill your insurance company as a courtesy. We will accept secondary insurances, as long as it is medigapped (automatic crossover). Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify exactly what insurance coverage is available on your policy. This can only be done on the day of your appointment if time permits. You as the policyholder are primarily responsible to verify benefits and provide our office with the current insurance coverage information and any other information that has changed on your account for each visit. We cannot guarantee payment of the benefits and subsequently you may be responsible for any coinsurance, deductibles, or fees for non-covered services that may result.

Referrals: If your insurance company requires a referral or preauthorization/pre-certification, **you are responsible for obtaining it.** We likely will not be able to obtain a referral on the date of service, (and this will be at our discretion if time permits). If the referral is not obtained, you understand that you have the option of rescheduling the appointment or paying for the visit out of pocket. You should call your primary doctor at least 24 hours in advance to confirm that your referral has been generated and faxed. **The most reliable method is to obtain it yourself.** You understand that if you do not secure a pre-authorization or pre-certification, benefit payments may be reduced or denied, and you will be responsible for any amounts not reimbursed by your insurer/benefits program.

Completion of Medical Forms/Letters: There is a $25.00 fee for completion of each form (including but not limited to, FMLA, disability forms, and handicap stickers), and Medical Letters relating to your condition. This fee is not reimbursable or billable to your insurance company and must be paid by you before the form is completed. Please allow 7 to 10 days for completion of any form.

Personal Injury: If your treatment by WCID is related to a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We do not accept letters of protection and subsequently cannot bill your attorney for charges incurred due to a personal injury case.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

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OFFICE FINANCIAL POLICY CONTINUED…

Returned Checks & Refunds: There is a fee (currently $25) for any checks returned by the bank. Refunds will be issued as soon as possible, but refunds can take 4-6 weeks from the date requested in some cases.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the balance, any new charges to the account, and the finance charge, if any.

Effective Date & Changes to Polices: Once you have signed this document you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. If you have any questions or require clarification on this policy please ask to speak with our Billing Department or our Administrator. We reserve the right to interpret, change, suspend, cancel, or dispute with or without notice all or any part of our policy, and procedures, at any time without verbal or written notification.

Release of Information & Confidentiality: You authorize the release of medical information by WCID to your insurance carrier, any physician participating in your health care, and any physician or health care provider to whom you may be subsequently referred. You understand that this authorization specifically includes all health information and medical records related to the patient for the purposes specified herein, including without limitation, the results of HIV or AIDS tests and related information, reproductive health information, substance use disorder ("SUD") treatment information, genetic information, information related sexually transmitted diseases ("STD"), and information related to mental health conditions, if on file with WCID. You understand that if You do not consent to the release of information for payment purposes, WCID and other health care providers will not be able to bill your insurance other third party and you may be billed directly for these services. In the event you do not pay the amount you are responsible for, you understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if 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.

Good Faith Estimates: You understand that as a requirement of the No Surprises Act, self-pay and uninsured patients will be provided with a good faith estimate, in writing or electronically, of the total expected cost of any health care items or services to be received by the Patient upon request or when scheduling such items or services, and such good faith estimates are only an estimate. You also understand that WCID attempts to provide all insured patients with a good faith estimate of the expected costs for scheduled items or services, but such good faith estimates are not required by statute or regulation, and such costs may change based on my insurance or benefits plan's coverage of services rendered and any changes to such insurance of benefits plan.

By signing below, you acknowledge that you are a legally competent adult, and you are responsible for any applicable payments for the services rendered by WCID to the patient named above (the "Patient"). You hereby assume and guarantee prompt payment of all expenses incurred for the services rendered to the Patient, including any applicable coinsurance, copayments, or deductibles due if such services are covered by an insurance plan or state or federal benefits program and claims are submitted by WCID for such services, or self-pay rates in the event that the Patient is not covered by an insurance plan or state or federal benefits program or in the event that the Patient and I choose not to submit claims to any applicable payor source. By signing below, you accept financial responsibility and agree to pay charges for all services ordered or otherwise provided to the Patient by the WCID, as applicable. You understand that any balance due for non-covered services, or as a result of being uninsured or under-insured, is payable immediately by cash, check, Visa or MasterCard. You further understand that if you fail to make payments upon their due date, your account associated with the Patient may be referred to a collection agent and/or attorney, and you agree to pay all collection related charges, including attorneys' fees.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. We are here to help you. West Coast Infectious Diseases complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

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Patient's Signature **Date**

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Relationship to Patient