Prime MD of Naples
COMPREHENSIVE PRIMARY CARE

PATIENT FINANCIAL AGREEMENT

Thank you for choosing PRIME MD OF NAPLES as your health care provider. We are committed to building a successful physician- patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc).

Co-pays : The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post- dated checks will be accepted.

Insurance Claims: Insurance is a contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. To properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Participating Insurances: If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full. However, as a courtesy, we will file your initial insurance claim and if not paid within 30 days you will be responsible.

Referrals and Pre authorizations: Certain health insurances require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, we will try to obtain it for you. We cannot guarantee approval from your insurance for the required services. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

Self-pay Accounts: Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Extended payment arrangements are available if needed. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress. Uninsured new patients are due 200$ at the time of the visit and follow up patients 100$.

CANCELLATION OF APPOINTMENTS

If it is necessary to cancel a scheduled appointment, we require at least 24 hours advance notice.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24-hour advance notice.

No-shows: A no-show is when a patient misses an appointment with no notice or shows up too late to the appointment to be seen.

Repeatedly missing visits jeopardizes your care. For this reason, ***after an ESTABLISHED patient has three late cancellations and/or no- shows or a NEW PATIENT has one cancellation or no-show, they will be discharged from the practice.***

COMPLETION OF FORMS POLICY

For us to better serve you, we request that you are aware of the following:

Your insurance company will not be billed as insurance companies do not reimburse for the time and judgment that are required to complete these forms. Please allow 7 business days for completion of forms.

Payment is required prior to completion of all form(s). The fee for completion of forms is 20$ to 40$ depending on time and complexity.

Returned Checks: The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Medical Record Copies: Patients requesting copies of medical records will not be charged if records are sent via secure email. If paper records are requested there is a 50$ fee. Attorneys and Insurance companies will be charged a 20$ fee, plus postage, plus: 0.25$ per page. A special handling fee of $10 will be charged if records must be delivered within 48 hours of the request.

Minors: The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy: It is our office policy that all past due accounts be sent three statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

Patient Full Name/ Guardian **Patient Signature** **Date**

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HIPPA PRIVACY AND RELEASE OF INFORMATION AUTHORIZATION

PATIENT NAME: ____ **PATIENT DOB: __________________**

I, ____________________________ hereby authorize PRIME MD OF NAPLES PLLC and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, its employees or agents have acted on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services. I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

I have read and understand the HIPAA/Privacy Policy for PRIME MD OF NAPLES, PLLC.

Patient Signature ___________________________________ Date ___________________

If applicable, Legal Representatives sign below: By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to authorization form.

Legal Guardian Signature ________________________________ Date ________________

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Authorization for the Use and Disclosure of Protected Health Information (PHI)

This form is used to authorize Prime MD of Naples to disclose protected health information to the person (s) entity designated below. Please complete the following information. All sections must be completed.

SECTION 1 – DEMOGRAPHIC INFORMATION:

Patient name and DOB : ____

SECTION 2 – PURPOSE OF THE AUTHORIZATION:

Please note that by signing this form, you will authorize Prime MD of Naples to disclose your protected health information for the following purposes. Describe the purpose of the authorization.

☐ Emergency care if incapacitated ☐ Ongoing care/treatment ☐ Other

SECTION 3 – PROTECTED HEALTH INFORMATION TO BE DISCLOSED:

Please indicate the specified protected health information you authorize us to disclose for the purpose stated above:

☐ Any/all concerning myself ☐ Related to a specific problem, please list: ___________________________________

☐ Related to a particular service date: _________________________

SECTION 4 – PERSON AUTHORIZED TO RECEIVE:

Please indicate the person(s) / entity and date to which you are authorizing Prime MD of Naples to disclosure the protected health information described above.

Name: ____DOB: __________________

Relationship to Patient: ____________________________________ Contact Number: _____________________

SECTION 5 – EXPIRATION

This authorization is in effect unless I revoke it in writing and/or I am no longer a patient with Prime MD of Naples.

SECTION 6 – STATEMENT OF UNDERSTANDING:

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits. I understand that Prime MD of Naples is released from all legal responsibility and/or liability that may arise from the release of such records. I understand that, if the person or entity I authorize to receive PHI described in this form is not a health plan, covered health care provider or

health care clearing house subject to federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by federal health information privacy laws.

I further understand by signing this authorization, I consent to the electronic transmissions of any prescription(s) to the pharmacy I provide. By signing this consent form, you also agree that Prime MD of Naples can request and use your prescription medication history from other healthcare provides and/or third-party pharmacy benefit payor for treatment purposes.

The undersigned represents that he/she has read and understands the information contained here, and that they agree to the terms and conditions of this authorization.

Patient/Authorized Signature: ____Date: ___________________

Printed Name: ____

Witness Name and Signature:____Date: __________________

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