

PATIENT FINANCIAL POLICY FOR REHLEN, BARTLOW, GOODMAN & BARON, MDS, INC. (3/03/2008)

It is the policy of this office to provide as much assistance as necessary concerning financial arrangements. We will try to ensure that you are aware of all possible financial matters on your first visit. As a service provided to you, we will bill your Health Plan, provide follow-up in 30 and 60 days (at which time you will be financially responsible) and a statement to you if there is any patient balance.

The undersigned hereby acknowledges that he/she has been informed that medical services provided may not be approved for payment/may not be covered services under their insurance plan. Therefore the undersigned agrees that he/she will bear full financial responsibility for payment of all charges for these services.

If applicable: Cash Patients. I hereby understand that I am a cash patient. I further understand that I will continue to be a cash patient even if I prove I have insurance at a later date for previous dates of treatment. If I am an HMO patient, I waive all rights for Rehlen, Bartlow, Goodman & Baron to bill my HMO nor am I eligible for a refund.

Initial _____

If applicable: Patient Financial Responsibility. I hereby attest that I am an eligible member of a contracted health plan as noted. I agree that should it be determined that I am ineligible or services are denied me under the Health Plan noted below, that I will be responsible for payment to doctors Rehlen, Bartlow, Goodman & Baron or their agents for those services deemed disallowed, ineligible or not covered.

Initial _____

If applicable: Out of Network Waiver Form. Your signature below signifies that you clearly understand that , Bartlow, Goodman & Baron, MDs, Inc. may not be a member of your medical group that you have signed up with. Because the doctor may not be on your plan, the expenses incurred for medical visits will be your responsibility. This means that you will have to pay the doctor's charges in full at the end of your visits.

Initial _____

If applicable: POS without authorization. You understand that in order to use the HMO option of your Health Plan that a prior authorization from your Medical Group is required. Without prior authorization, your Medical Group is not responsible to pay for any services performed today. You choose to use your PPO, POS, or Self Referral option and agree that you are financially responsible for any co-insurance, deductible and co-payment in accordance with your policy. You accept full financial responsibility for services provided and that your Medical Group will not reimburse you for these expenses.

Initial _____

If applicable: Access Plus (Blue Cross/Blue Shield). This plan allows you to come for an evaluation to specialists within your selected IPA/Medical Group. The physician is allowed to do a consultation and, in certain IPAs, treat. If the recommended treatment is not within our responsibility, then you have to go back to your PCP for further evaluation and/or treatment.

Initial _____

Please feel free to contact our billing department for any assistance or information that you may need. They will be happy to answer any questions that you may have concerning your account. Sometimes, problems can be worked out with just a phone call or letter. We do offer Visa/Mastercard as a payment option. It is also our policy to report bad accounts to a credit agency.

I hereby assume all financial responsibility for the account of _____. I will ensure that I provide accurate, correct information for proper billing at all times and notify Rehlen, Bartlow, Goodman & Baron, MDs, Inc. of any changes at any time a change occurs.

Date: _____ **Responsible person's signature:** X _____
(Authorized adult/guardian/emancipated minor)

Date: _____ Witness: _____