REVOLUTION PSYCHIATRIC & ADDICTION TREATMENT

FINANCIAL POLICIES AND PROCEDURES

Richard E. Repass, MD * Revolution Psychiatric and Addiction Treatment 2737 78th Avenue SE Suite 100 Mercer Island, WA 98040

Thank you for the opportunity to provide your treatment at Revolution Psychiatric and Addiction Treatment. We believe that all patients should have the best medical care that can be provided. In order for us to provide you with the highest quality medical care and current technology, we must ensure that we are able to meet the expenses necessary to operate this facility. To ensure that these expenses are met, we provide you with this Agreement regarding our financial policy and your agreement to pay for services provided. Please sign and date this Agreement on the last page to indicate you accept these terms.

PAYMENT AT TIME OF SERVICE, FEES AND COLLECTIONS

Your insurance policy is a contract between you and your insurance company. We generally cannot become involved in disputes between you and your insurance carrier. We do not get involved in such matters as disputes regarding deductibles, copayments, non-covered charges and "usual and customary" charges. We provide your insurance carrier with information regarding your diagnosis and treatment and they reimburse us based upon our contract with them.

You are responsible for timely payment on your account. We require that you pay any amount not covered by your insurance such as deductibles and copayments under your policy within 30 days of service. We encourage payment on the day of service and may require that in the future. For billing questions, please call AdvancedMD at **855-255-1036**. Revolution is required in accordance with its contract with your insurer to collect from you your deductibles and copayments. Our billing department will determine your copay and how much of your yearly deductible under your policy has been met for the year. If needed, we will work with you to arrange a payment plan, however an acceptable minimum monthly payment will be required.

It is your responsibility to provide us with your current insurance card and photo identification at every visit so that we may bill the insurance company in a timely fashion. It will be reviewed or copied every time you are here for a visit, no matter how frequently you are seen. If a claim is rejected because your insurance does not cover the type of service rendered, you will be held responsible for the outstanding balance. Please call the telephone number on your insurance card before your appointment and they will assist you in finding out whether the service to be provided at the appointment is covered, what your copay is, and what your deductible is. It is your responsibility to understand your insurance coverage. If your insurance does not cover the cost of your visit or procedure, you will be responsible for the charges for all services rendered. Please educate yourself as to your coverage so that office visits, procedures, testing, and specialist referrals may be arranged to best suit your needs.

Once we determine your personal financial obligation or after your insurance company reimburses Revolution, for a portion of your care, we may mail you a statement. Payment is expected upon receipt of the statement. Any account past due by 90 days or more may be subject to submission to our collection agency. If your account becomes delinquent and is placed into

our collection process, collection fees will be your responsibility and added to your balance. Revolution reserves the right to discharge any patient at this point. By signing our financial policy, you agree to pay these added fees, along with any and all costs associated with the collection of your account, including interest charges. If a new problem is encountered, or if changes in treatment of a preexisting condition are discussed in the process of performing a visit or exam, an additional copay and deductible payment may be incurred.

CREDIT CARD ON FILE

Once payments are determined, you may no longer receive bills from our billing company in the mail. We require a credit, debit card, or direct bank account on file with our office. Statements are wasteful of paper, stamps, and envelopes and are not efficient. We need to ensure that we have a guarantee of payment on file in our office. Times are changing in healthcare, and we need to be sure that patient responsible balances are paid in a timely manner. We have to be fair and apply the policy to all patients. You will receive a letter in the mail from your insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits, or EOB. This letter tells you exactly, according to your health insurance coverage, how much of your health care bill is your responsibility and how much is the responsibility of your insurance to pay. We receive the same letter that you do. It arrives about 20-30 days after your appointment. We look at each Explanation of Benefits (EOB) carefully and determine what your insurance has determined as patient responsibility. This is the same way we normally determine how much to send you a bill for in the mail.

We do not store your sensitive credit card information in our office. We store it in a secure fashion with a reputable financial firm called a gateway. We access your information only on this site to process a payment. You will be required to sign a credit card on file authorization statement that will allow us to charge an amount agreeable to each of us until your balance is paid in full. We will always work with you to understand if there has been a mistake, and we will refund you if we have made a billing error. We will only charge the amount that we are instructed to by your insurance carrier, in the letter they send to us and the amount that you have agreed to, in the same way that we normally determine how much to send you a bill for in the mail.

ELECTIVE PROCEDURES/NON-COVERED PROCEDURES

Patients are required to pay the estimated self-pay portion of elective/non-covered procedures prior to services being rendered base on insurance verification and eligibility of benefits.

SUBMISSION OF CLAIMS

We will submit your insurance claims. However, it is important to remember that your insurance is a contract between you and your insurer, and you are ultimately financially responsible for any services you receive at this office.

PAYMENT OPTIONS

Our office accepts most credit and debit cards, as well as bank checks. There will be a $25 fee for all returned checks. Anytime a co-pay, deductible or balance is due, we will charge the fee to your credit card or account on file.

MEDICARE PATIENTS

If you have Medicare as your primary insurance carrier, but you do not have a secondary insurance, you are responsible for the deductible, copay and co insurance at the time of service. You are also responsible to pay for services not covered by your Medicare insurance unless you have a secondary insurance. You will be required to sign an Advance Beneficiary Notice for non-covered services.

NON-CONTRACTED INSURANCE (Out of Network)

If you have an insurance plan that we do not participate with, you may have out of network benefits. These benefits typically have a higher copay, coinsurance, and/or deductible out of pocket cost. You will be considered a self-pay, uninsured patient if you do NOT have out of network benefits.

UNINSURED/SELF PAY

Payment is expected at each visit, or as arranged. It is expected that each patient the full balance of all charges incurred. We will assist with determining expected costs of treatment over time.

MISSED APPOINTMENTS/NO SHOWS/LATE FOR APPOINTMENT

We understand that you may not be able to keep all of your scheduled appointments or might occasionally be late. Please understand that missed appointments have a detrimental impact on our practice and other patients. They also affect our ability to serve other patients in need of medical care. We understand there may be inclement weather or other circumstances that may require you to cancel your appointment. If you must cancel or reschedule your appointment, please do so at least 24 hours in advance. Failure to cancel or reschedule an appointment at least 24 hours in advance will be considered a no-show. We reserve the right to charge you $50.00 for any no-show if permitted by law and your insurance contract. Payment of the missed appointment will be required prior to scheduling another appointment. Revolution reserves the right to terminate any patient with more than three no show appointments upon 30 days written notice to the patient to seek medical help from another practice. If you are running late on the day of your appointment due to unforeseen circumstances, please contact our office immediately so that we can determine whether we can see you that day or if we will need to reschedule your appointment. If you are more than 15 minutes late for an appointment, Revolution may need to reschedule your appointment.

REFERRALS

If your insurance carrier requires a referral or authorization for your visit, it is your responsibility to make sure that our office receives current valid authorization. If you do not have a valid referral or authorization at the time of service, we will be unable to treat you until a valid authorization/referral is obtained, and you may be sent back to your primary care physician to obtain authorization prior to being treated or full payment will be expected at the time of service. Please remember that it is your responsibility to make sure we are on your plan's provider listing. We appreciate your understanding of the ever-changing requirements of managed care plans and our position to adhere to their policies or requirements.

FORMS AND MEDICAL RECORDS FEES

Due to the increasing costs of providing our patients with the highest standards of care, we must impose a charge for certain records and forms. It takes time for our providers and staff to retrieve and copy files, complete forms and write letters. Charges may apply for: FMLA, Disability, Corps, School forms not completed during an appointment, and Supplemental insurance forms, letters, extensive forms with review of medical records, copies of records for personal use.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Revolution Psychiatric and Addiction Treatment: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for all services provided to me by Revolution Psychiatric and Addiction Treatment. This order will remain in effect until revoked by me in writing. I have received the practice's Medical Authorization for Release / Disclosure of Protected Health Information / HIPAA Privacy Notice.

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above named health care provider any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above named health care provider or its attorneys in order to claim such medical benefits. In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or choose an action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee

and/or designated representative (above named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit

evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

Acknowledgement of Notice of Financial Policies and Procedures

In signing below, I testify to both reading and understanding a presented copy of the Notice of Financial Policies and Procedures for the office of Richard Repass M.D.

_____ _____
Signature Date

Patient Name (PRINT): _____

_____ _____
Signature Date

Name of Person Financially
Responsible for Patient's
Treatment (PRINT):_____