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 choosing **Revolution Psychiatric and Addiction Treatment** as your premier community mental health, detox and telepsychiatry provider. Our caring team of healthcare professionals is committed to providing our valued patients with individualized treatment and person-centered care. Our Founding Director, Dr. Richard E. Repass, MD is double board certified in both Psychiatry and Addiction Medicine with more than a decade of cutting-edge experience serving the needs of our community. In addition to offering a full range of outpatient detoxification services for those suffering from alcohol and substance use dependency, we specialize in delivering a wide array of person-centered and holistic treatment options including psychopharmacology, BR+NAD infusions, and medication-assisted treatment (MAT).

In order to ensure the highest quality of service we ask that you please review our financial policy. Please sign and date this agreement on the last page to indicate your acceptance of these and your consent to pay for services provided. Once again, it's truly our privilege to serve you and we look forward to working collaboratively with you toward meeting all your health and wellness goals.

PAYMENT ARRANGEMENTS

Payments are requested at the time of service, and any amount not covered by your insurance such as deductibles and copayments under your policy are required within 30 days of service. For billing questions, please contact our office (206-695-2707). We accept cash, check, VISA, MasterCard, Discover, American Express and MyTreatmentLender.com. There is a $25 fee for returned checks. An authorization for credit, debit card, or direct bank account may be required to be maintained on file within a secure server for automatic debit. If needed, we will work with you to arrange a payment plan, however an acceptable minimum monthly payment will be required. Any account past due by 90 days or more may be subject to submission to our collection agency.

INSURANCE

As a courtesy to our patients, we do bill participating insurance companies and ask that you pay your deductible, copayments and coinsurance. We require a copy of your current insurance card and photo identification so that we may bill the insurance company in a timely fashion. Please understand that while all attempts are made to confirm benefits and eligibility prior to your treatment this is an estimate only.

Although we will assist you in ensuring prior authorization requirements are verified prior to any treatment, it is not a guarantee. Please be aware that some services provided may be non-covered and considered not reasonable and necessary under your insurance plan. It is your responsibility to know your coverage. If payment is not received from your insurance company, you may be expected to pay the balance in full. It is your responsibility to notify us of any insurance coverage changes.

You will receive a letter in the mail from your insurance carrier called an Explanation of Benefits, or EOB. This letter tells you exactly, according to your health insurance coverage, what portion of your health care bill is your responsibility and what amount your insurance will pay.

MANAGED CARE REFERRALS

If you are enrolled in a managed care insurance plan (i.e. HMO or POS), your insurance carrier requires that you obtain a referral from your primary care physician (PCP) before receiving services. We will work with your PCP to obtain that referral, however, services received without a referral or proper authorization will be your financial responsibility.

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 coinsurance 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 pay the full balance of all charges incurred. We will assist with determining expected costs of treatment over time.

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 based on insurance verification and eligibility of benefits. You will also be required to sign an Advance Beneficiary Notice for non-covered services.

MISSED APPOINTMENTS/LATE CANCELLATIONS

We understand that life happens but prioritizing your appointment time represents a win-win for everyone! Please understand that missed appointments affect our ability to serve other patients in need of medical care. We ask that you check in with us in the event that you are unable to meet at your scheduled appointment time so that we can reschedule. Cancellations are requested 48 hours in advance of the scheduled appointment, and we reserve the right to charge a $50.00 fee for a missed appointment without proper notification. For **BR+NAD** treatments the fee is $100, per day missed, for any of the remaining 10 days scheduled; those fees would be credited back for subsequent treatments attended.

TELEMEDICINE:

With the COVID-19 crisis, appointments conducted via telemedicine have become equivalent to in-office visits. It is at present unclear how telemedicine will be covered as the landscape of medical practice evolves, and so cost and coverage may change in the future.

FORMS AND MEDICAL RECORDS FEES

Due to the increasing costs of providing our patients with the highest standards of care, we may 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

***[What is ERISA? – link]*:** (https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/what-is-erisa)

I hereby assign and convey directly to *Revolution Psychiatric and Addiction Treatment*, 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 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. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above named 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.

In designating *Revolution Psychiatric and Addiction Treatment* as my assigned authorized representative, I convey to that provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications delivered by that same provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The above named provider is thus 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. As my assignee and designated authorized representative, the above-named provider 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

NOTE: Please read the above agreements carefully and make sure that you understand all the terms and conditions before signing below. If you do not understand, please review contents with the staff prior to signing. Your signature confirms that you have read and fully understand all the agreements, terms, and conditions above as presented, for the office of Richard Repass, M.D. Agreed and Accepted by:

_____ _____

Signature Date

Patient Name (PRINT): _____

_____ _____

Signature Date

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