NORTHEAST MEDICAL, PC

Consent for Treatment & Financial Responsibility Agreement

We are committed to providing you with the best possible care, and we are pleased to discuss our policies related to insurance and fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility. The following is our policy for accepting insurance and procedures for payment if you no longer have insurance coverage including Medicaid Coverage.

Consent for Treatment

- I voluntarily consent to treatment at Northeast Medical, PC. I hereby give permission to the physician or provider in charge of my care to administer any treatment deemed necessary or advisable. In addition to all other consents, I specifically consent to medical procedures and test necessary to aid and assist in my diagnosis and treatment.

Financial Agreement

- I permit Northeast Medical, PC to bill my insurance company, if any, for services rendered.
- I agree to assume full, primary responsibility for payment of all charges for services I receive from Northeast Medical, PC, if not paid by my insurance company or other party.
- I agree that Northeast Medical, PC, and its medical staff may use and disclose my protected health information, as necessary, to treat my condition, obtain payment for treatment and conduct normal business operations. Such disclosures include those to other hospitals and/or health care providers involved in my care. I understand that the information used and disclosed for these purposes may contain my name and/or other information that could be used to directly identify me. This information may include information about psychiatric care or other sensitive information.
- I agree to pay any amount of money I owe for the services within 30 days after I receive a bill.

Note: It is patient's responsibility to confirm with their insurance to assure that we participate in health insurance plan.

Assignment of Benefits

- I assign to Northeast Medical, PC any monies and benefits payable to me under any health insurance or other insurance policy, governmental program, or other party providing benefits for all, or a part of the services provided.
- I agree that any credit balance after payment from such sources may be applied on any account at Northeast Medical, PC.
- I certify that the information I have provided regarding my insurance is correct and current.
- I agree to pay Northeast Medical, PC within 30 days of receiving any payment made directly to me by my insurance company or other party that is connected to charges for services.
- I agree to complete any forms necessary to obtain payment or assignment of such monies or benefits.
- I give permission to Northeast Medical, PC to request payment for services for no-fault benefits, workers compensation benefits, or any other benefits available to me under any governmental programs for any unpaid balance of my bill. This will be done for me if I am eligible for benefits and do not submit a request for payment of services from these government programs.
- I understand that payment for services rendered is subject to the deductibles, co-pays, and in-network/out-network benefits specified by my individual insurance policy.

Patient Responsibility

- I accept financial responsibility for the patient responsibility portion of the fees.
- I understand that if my insurance company pays me directly for services rendered by the practice, I must remit that payment to Northeast Medical, PC.
- I agree that in the event my insurance coverage changes, I must notify Northeast Medical, PC of the changes to determine whether Northeast Medical, PC participates with my new insurance and/or whether services are covered by my insurance.
- I agree that I will bring my insurance card to each session for authorization and verification.
- I understand that if I do not pay the patients responsibility portion of my bill in a timely manner, I may be referred to a collection agency as part of a continued collection effort.
- I agree that I will provide at least 24-hour notice for appointment cancellations, and failure to do so will result in no show fee of $35.

I agree to all terms and conditions listed in this document.

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Patient/Gurdian Signature **Date**