PATIENT FINANCIAL AGREEMENT & ACKNOWLEDGEMENT OF OFFICE POLICIES

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. United Physician Group ("UPG") believes that part of good health care practice is to establish and communicate an office and financial policy to our patients proactively and effectively. We are dedicated to providing the best possible care for you, and we want you to have a full understanding of our policies.

1. **INFORMATION**: Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information.

2. **PAYMENT:** Payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept Debit Cards, Visa, Mastercard, Discover, and Care Credit on select procedures. Payment will include any unmet deductible, co-insurance, co-payment amount and/or charges not covered by your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. All non-filed services are expected to be paid at the time of service.

3. **INSURANCE:** We are participating providers with most insurance plans. We will file all of the claims for these plans. **Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. It is your responsibility to provide the most recent and up to date insurance information to our office and to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company. As a courtesy to our patients, we will verify your insurance coverage based on the information provided by you, however, our verification is not a guarantee of benefits payable by your insurance. If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance.** If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your services. **In order to bill your insurance and to meet filing guidelines we do ask for a copy of your insurance card and a photo ID.**

4. If our providers are not listed in your plan's network, you may be responsible for partial or full payment.

5. **NETWORK STATUS**: If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company. Your claim may be processed Out-of-Network if we are not contracted with your insurer. Some Out-of-Network benefits have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In Network rate. If we do not contract with your insurance company, you will be expected to pay for all services rendered at the time of service. If needed, we will provide you with a statement that you can submit to your insurance company for reimbursement.

6. **POLICY ON NON-COVERED SERVICES:** This office offers access to many innovative services and procedures some of them are deemed as "not covered" by insurance. In some cases, you will be given an ABN (Advanced Beneficiary Notice) for these types of services/procedures before they are provided/performed. You will be responsible for payment in full at the time of service.

7. **REFERRALS:** If your insurance company requires a referral, it is the patient's responsibility (or guarantor) to obtain the referral prior to your appointment.

8. **ANCILLARY SERVICES:** I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services.

9. **RESPONSIBILITY FOR PAYMENT:** I understand that I, personally, am financially responsible to UPG for charges not covered by the assignment of insurance benefits and all non-covered charges.

10. **AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize UPG to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to UPG all payments otherwise payable to me for UPG services.

11. **CONSENT AND DISCLOSURES:** I voluntarily consent to medical treatment for myself and/or my dependents.

12. **RELEASE OF INFORMATION:** I hereby authorize and direct UPG to release (verbally or in writing) confidential medical information to any person, entity, government agencies, insurance carriers, or others who are financially liable to UPG for charges for medical treatment for claims processing, quality management, utilization review, transfer of medical care, and follow up purposes. I understand that a copy of this document may be used with the same effectiveness as an original.

13. **SELF PAY PATIENTS WHO ARE INSURED:**

    - Self-pay patients will be identified when they make the initial contact with the office and will be defined as a patient who:
    - has no health insurance coverage of any kind, including federal and state health care programs such as Medicare and Medicaid or other insurance coverage such as insurance provided by a school, or AFLAC
    - does not claim third party liability for the patient's health care treatment
    - is not eligible for worker's compensation coverage; and
    - has no other responsible party covering the expenses associated with the care received from our clinics

Self-pay patients will be required to pay in full for their visit at time of check in. Any additional charges incurred will be collected at check out. All charges are due on the date of service.

14. **BILLING AND COLLECTION FEES:** UPG will submit a claim for payment to your insurance company. In the event your insurance carrier/company denies the services provided, you will be responsible for the payment in full. We appreciate prompt payment in full for any outstanding balance. **Failure to settle your account within 90 days after notification will result in submission to an outside collection agency.**

15. **NO SHOW POLICY:** We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than a 24-hour notice. Patients who do not show up nor provide more than a 24-hour notice are considered a NO SHOW and will be subject to a _$30___no show fee. **Patients who No-Show three (3) or more times in a 12-month period, may be dismissed from the practice.**

16. **MEDICARE BENEFICIARIES**: I request that payment of authorized Medicare benefits be made to UPG. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I certify that I have read and agree to the United Physician Group (UPG) Financial and Billing policy. I also understand and agree that such terms may be amended by the practice at any time.

Signature of Patient/Guarantor, if applicable	Date

Disclaimer: United Physician Group does not consider an individual seeking treatment to be a patient until a preliminary assessment is completed and the individual has been notified that he or she has been accepted as a patient; simply making an appointment does not automatically initiate doctor-patient relationship.