Financial Responsibility Policy

Ver 1-19

Must be read and signed by <u>all adults</u> and emancipated minors. Please read <u>each</u> item carefully.

Patient Name: _____ Date of Birth: _____

Payment Policy: *It is the policy of TriValley Primary Care to require payment in full on the day of service. This includes health plan co-payments, co-insurances, deductibles, and charges for non-covered services.*

Responsible Party (Self Pay): I agree that I am responsible to pay for services rendered if I do not have insurance that covers such services, or if I must file a claim to my insurance company. Payment is due, payable, and expected on the day of service.

Responsible Party (Insurance Coverage): I agree to pay on the day of service co-insurances, co-payments, and deductibles related to services rendered or to be rendered; as well as charges for non-covered services, except as limited by law or contract. Furthermore, I agree to pay within thirty (30) days following notice to me that: (1) my coverage has denied payment; or, (2) my insurer has not paid within 60 days of the last claim submitted; or (3) there is a balance remaining after insurance payment, except as limited by law or contract.

Failure to Pay: I understand that if I fail to pay any balance on my account within thirty (30) days of date of service, my account will be delinquent and may be referred to an attorney or collection agency for collection. In the event of such default and referral for legal action, I agree to (i) pay interest on the delinquent account balance at the rate of 1.5% per month from and after the date of default through the date such balance is paid in full and (ii) pay all costs of collection, including reasonable attorneys' fees and expenses, collection agency fees of 25% of the original balance referred, and court costs. Payment in full of any delinquent balance is required prior to future appointments. The provisions of this section apply to all current balances for which I am responsible that remain unpaid 30 days after the date I sign this document. Returned checks will be assessed a fee of not less than a $20.

Minors, Dependents, and Wards: If the above named patient is a minor, dependent or ward, I represent that I am the parent or guardian of this patient and I agree to be responsible for payment for services rendered to this patient not otherwise covered by insurance or a health plan except where limited by law, court decree or contract. In the former case then, the terms of this policy apply to me as if I had been rendered the service. I agree that account credits in this patient's name may be applied to any account balance for which I or my spouse may be responsible, except where limited by law, court decree or contract.

Transfer of Account Credits/Small Balance Forgiven: I agree that account credits in my name may be applied to any account balance for which I or my spouse may be responsible, except where limited by law, court decree or contract. I hereby disclaim a patient account credit of less than $2.00 in recognition that TriValley Primary Care shall forgive a patient account balance that I owe of less than $2.00. Note: By contract, $2.00 co-pays (and all other co-pays) **must** be paid.

Release of Information: I authorize TriValley Primary Care to release any medical and non-medical information 1) to my insurance company (or Medicare, or health maintenance organization, or a fiscal intermediary), needed to determine benefits, or the benefits payable for related services; 2) to my attorney as requested, and 3) to another physician's office, other practitioner, or diagnostic/treatment facility needed to support my care. This authorization will remain in effect until revoked by me in writing.

Assignment of Insurance Benefits: I hereby assign all medical benefits, to include major medical benefits to which I am entitled; private insurance, and benefits from any other health plans, to TriValley Primary Care. This assignment will remain in effect until revoked by me in writing.

My signature indicates that I have read the above statements, and fully understand and accept (<u>and intend to be legally bound to</u>) the terms and conditions as presented. A photocopy of this Agreement, including insurance benefit assignment, is as valid as the original, and therefore, may be used in lieu of the original.

Date: _____ **Signature** _____

Patient's Signature (SEAL) or Parent/Legal Guardian/Responsible Party/Guarantor (SEAL)