SOUNDHEALTH SERVICES

Financial Agreement

We are committed to providing you with the best possible care and are pleased to discuss our professional 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.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTO-COPY YOUR INSURANCE CARD(S) AND A PHOTO I.D. FOR YOUR FILE.

- **APPOINTMENTS** - 24 hours notice must be provided in the event that you cannot keep an appointment. Should you not provide this notice, a cancellation fee up to $35 may be added to your account. Cancellations for ancillary services will have a higher fee.
- **REFERRALS** - If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral you will be asked to reschedule your appointment.
- **CO-PAYMENTS** - We MUST collect your carrier designated co-pay. This payment is expected at time of service. Please be prepared to pay the co-pay at each visit.
- **PROCEDURES** - Any procedure performed in this office could be deemed surgical by your insurance company and all co-pays, coinsurances, and deductibles will apply.
- **FMLA AND OR WORKMAN'S COMP** - There is a $25.00 charge for the completion of work comp or FMLA forms.
- **SURGERY DEPOSITS** - If you and your physician determine that your course of care requires surgery, a surgical deposit will be collected at the time of scheduling. Our scheduling coordinators will work with you to determine estimated insurance payment and estimated patient responsibility.
- **OUT OF NETWORK PLANS** - You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible.
  If we do not "participate" with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.

  Private insurance authorization for assignment of benefits/information release: I, the undersigned, authorize payment of medical benefits to Sound Health Services, P.C. for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or the agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS** - Payment is expected at the time of service.
- **MEDICARE** - We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% coinsurance, which can be billed to a secondary insurance if you have one.

  Medicare lifetime signature on file: I request that payment of authorized Medicare benefits to be made on my behalf to Sound Health Services, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and it's agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering of claims.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** - The parent who consents to the treatment of the minor child is responsible for payment of services rendered, Sound Health Services, P.C. will not be involved with separation or divorce disputes.
- INSUFFICIENT FUND CHECKS - A $25.00 fee will be charged to the patient's account for checks returned due to non-sufficient funds.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be obligated to pay us, to cover the costs of using a collection agency, an additonal amount equal to 30 % of your total unpaid balance at the time a collection agency is brought in to collect your account. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AM EX, DISCOVER, OR CARE CREDIT

Responsible Party/Patient's Signature **Date**