Baymeadows Healthcare

Financial Agreement and Notice of Privacy Practices

FINANCIAL

If you are covered by Medicare, Tricare, or any other of our managed care plans, we will file your insurance claim. YOU ARE RESPONSIBLE FOR ANY CO-PAY, CO-INSURANCE, DEDUCTIBLE, OR NONCOVERED SERVICE FEES AT THE TIME OF YOUR VISIT. If we do not participate with your insurance company and/or you are self-pay, you will be responsible for full payment at the time of your visit. You will be given an insurance claim for to file for reimbursement to you by your insurance carrier. We will file with all insurance plans for our professional fees for any hospital admissions.

In the event that your insurance company does not pay the full balance within 45 days, we will notify you so that you may contact your insurance carrier. Payment responsibility rests with the patient. Therefore, after 45 days from filing your claim, payment is due and payable by you.

The parent's (or guardians) will be responsible for full payment unless covered by a participating managed care plan. Authorization to treat an UNACCOMPANIED MINOR must be on file with our office.

I also understand should this matter be placed in the hands of a collection agency or an attorney for collection, I am financially responsible for additional charges that may occur. I also understand that there could be up to a 40% increase over the actual balance if my account is sent to collections.

I have been advised that it is my responsibility to make sure my insurance and mailing information is kept up to date at all times.

Payment arrangements for hardship or emergency situations may be made in advance with the Office Manager prior to services being rendered.

Workers' Compensation and Auto Accident patients will be seen only after the proper authorization and paperwork has been received from your employer and their insurance company approving authorization for service.

Other: A $30.00 fee will be billed to you if you fail to cancel your appointment with a 24-hour notice. Should it become necessary to use the services of a collection agency to collect unpaid fees, you will be responsible for any and all costs incurred for that purpose.

I hereby authorize Baymeadows Primary Care, Inc. to bill my insurance company directly for services rendered. I understand that I am financially responsible for fees not covered by my insurance company. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or related Medicare claims. I certify that the information provided on this form is currently correct and I acknowledge understanding of the financial policy as described above.

HIPAA

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our office.

- **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to the practice's office personnel who are involved in taking care of you at the office or elsewhere. We also may disclose medical information about you to people outside our office who may be involved in your care after you leave the office, such as family members or others we use to provide services that are part of your care, provided you have consented to such disclosure. These entities include third-party physicians, hospitals, nursing homes, pharmacies, and clinical laboratories with whom the office consults or makes referrals.
- **Appointment Reminders**. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the office.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care, provided you have consented to such disclosure. We may also give information to someone who helps pay for your care.
- **As Required By Law**. We will disclose medical information about you when required to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Coroners, Medical Examiners, and Funeral Directors**. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the office to funeral directors as necessary to perform their duties.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Baymeadows Primary Care, Inc. may decline to provide treatment to me.

"Personal representative whom I give consent for Baymeadows Healthcare to release my private health information in the event I am incapacitated is named below.

PERSONAL REPRESENTATIVE________________________________

Relationship: ____

By signing below I am agreeing to the financial terms and acknowledge that I received a copy of Notice of Privacy Practices.

Patients Name: ___________________________ .DOB: ___________

Date: __________

Signature: ____

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