

FINANCIAL POLICY & CONSENT TO TREAT

Insured Patients: If you have insurance coverage, as a courtesy Prestige Medical Group (PMG) will file claims with your insurance company. In order to provide this service, we must have all current insurance information including a valid driver's license or photo ID. Patients who do not provide the required information may be registered as self-pay and payment in full may be expected at the time of service.

It is your responsibility to understand your insurance coverage and benefits. Patients are responsible for deductibles, copayments, coinsurance, and any services not covered by their insurance plan. Payment of patient responsibility balances is expected at the time of service unless prior arrangements have been made.

For your convenience we accept cash, credit cards, and debit cards. Personal checks are not accepted. Any balances assigned as patient responsibility that remain unpaid may be subject to collection activities after 90 days.

We are required by our contract with your insurer to collect your portion of the visit's charges. **It is your responsibility to pay any deductible, co-pay, or any other portion of the charge as specified by your plan.** Any medical services **not covered** by the patient's plan are the patient's responsibility for paying the charges within 30 days of our statement if not collected at the time service was rendered. For your convenience we accept cash, money order, and all major credit / debit cards at our office. ***We do NOT accept personal checks.*** Any payments received may be applied to any unpaid bill(s) for which the patient is liable. Any and all balances assigned as patient responsibility may be subject to collection efforts after 90 days, as well as credit reporting.

Assignment of Benefits

I authorize payment of medical benefits directly to Prestige Medical Group for services rendered. I understand that I am financially responsible for charges not covered by insurance, including deductibles, copayments, and coinsurance.

Network Participation

PMG participates with many insurance plans; however, participation may vary by provider and location. It is the patient's responsibility to verify that PMG and the treating provider are in-network with their insurance plan prior to receiving services.

Missed Appointment / Late Cancellation Fee

We require **at least 24 hours' notice** to cancel or reschedule an appointment.

Appointments that are **missed or cancelled with less than 24 hours' notice** may be subject to a **\$50 missed appointment fee**. This fee is **not billable to insurance and is the patient's responsibility**.

Repeated missed appointments may result in **restrictions on future scheduling**.

Initials _____

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SIGNATURE REQUIRED ON BACK

Lab Testing:

Laboratory services may be performed by an independent laboratory such as Quest Diagnostics. These laboratories are separate entities and may bill patients directly. It is the patient's responsibility to verify insurance coverage for laboratory services. Laboratory services are provided by Quest Diagnostics. They are not affiliated with PMG and there may be an additional charge if your insurance coverage does not include this lab. Please check with your insurance co. Any questions about billing from laboratories are to be resolved by contacting the lab company directly.

All Physicals:

Your provider may recommend an annual physical examination. Coverage for physical exams varies by insurance plan. It is the patient's responsibility to verify coverage with their insurance provider.

Some services discussed or performed during an annual physical exam may be considered diagnostic or problem-focused by your insurance plan. These services may result in additional charges such as copayments, coinsurance, or deductible amounts. Coverage for preventive services varies by insurance plan and the patient is responsible for verifying coverage.

Your provider may recommend that you have an annual physical. Each insurance plan has different benefits, and each policy pays for physicals differently. It will be the patient's responsibility to verify with his or her insurance company to see if and what is covered for an annual physical. If the services are rendered and your insurance does not pay for the services, then the patient will be responsible for the visit. When tests are ordered, the patient **will** be expected to return to the office to discuss results. Please note the follow-up visit is **not** part of the PE and therefore your insurance does charge a copay or coinsurance.

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Referrals:

If your insurance plan requires a referral for services outside of our practice, the referral must be obtained prior to your appointment. Some insurance plans require referrals to be issued by your primary care provider.

If your plan requires a referral for diagnostic testing performed outside our office or a referral to another provider, the **referral must be obtained prior to your appointment**. We **require 10 business days** to obtain your referral authorization. Some plans may require these to be issued by your primary care physician. Once your appointment is scheduled and you have verified with your plan that referral is needed, call our office with the following information:

1. Date of appointment
2. Physician's name or facility, their phone number and fax number
3. If it is a diagnostic test, we need the name of the test and location of the test.
4. Your insurance plan's name and your identification number

Patient Authorizations:

I consent to evaluation, treatment, and medical services provided by Prestige Medical Group and its providers. I authorize the release of medical information necessary for treatment, payment, and healthcare operations, including communication with insurance companies and other healthcare providers.

I understand that I am financially responsible for all charges not covered by my insurance plan. Balances remaining unpaid after 90 days may be referred to by a collection agency and may incur additional collection or legal fees as permitted by law.

I hereby give authorization to be treated as a patient at Prestige Medical Group, and I authorize release of medical information necessary to pay the claim.

By my signature below, I hereby authorize PMG and the physicians, and staff to release medical and other information acquired during my exam/ treatment to the necessary insurance companies, third- party payors, or other physicians or healthcare entities required to participate in my care.

By my signature below, I hereby authorize assignment of financial benefits directly to PMG for services rendered under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment; I further understand that any balances not paid by my insurance within 90 days are the patients/my responsibility. I understand that account balances not paid within 90 days will be sent to collections and that I may be charged collection charges up to 40% and / or court costs and attorney fees.

I have read and understand this explanation of my responsibilities for services I receive from Prestige Primary Care providers:

Printed Name / Date of Birth

DATE

Signature

Notice of Your Right to a Good Faith Estimate

Under the No Surprises Act, patients who are uninsured or choose not to use insurance have the right to receive a Good Faith Estimate of the expected cost of medical services before those services are provided.