Patient Financial Responsibility Statement for ParkView Health and Wellness Center

Thank you for choosing ParkView Health and Wellness Center for your healthcare needs.

Please read the section headings below to find which method of payment best suits your needs and wishes for your financial responsibility.

I. NOT USING INSURANCE/SELF-PAYING AT TIME OF SERVICE OR PURCHASE OF PRODUCT:

If you are self-paying, your payment is due at the time of service or purchase of products. We do not carry account balances on cash accounts. We ask that you plan to fulfill your financial obligation each time you receive service or purchase product at ParkView Health and Wellness Center. We do accept the following methods of payment: Cash, Check, ATM/Debit, Credit Card (Visa, MC, AMEX)

II. INSURANCE:

1. As a patient, prior to any visit, please know;
    a. your Insurance policy is to help you with your financial responsibility, **not** to pay for all of your healthcare.
    b. whether or not your insurance plan is contracted with ParkView Health and Wellness Center (I.e. "In-network.")
    c. your insurance plan benefits for you and your family.
    d. your responsibility for deductibles, co- insurance, and co-payments.

    (In other words, you are responsible for knowing your own policy).

2. We will verify your insurance benefits on your behalf and review the information with you either by phone or in person. However, please know that the professional relationship is with you (as a patient) and your insurance carrier. ParkView Health and Wellness Center is not a part of that professional relationship

Types of Insurance

1. **IN-NETWORK**

If your Insurance carrier has a prior financial contract with ParkView Health and Wellness Center, the parameters of that policy will apply. These are policy specific and not set by ParkView. Once the "number of visits" for your "in-network" policy has been used/completed, you may then qualify for self-pay options here at ParkView.

2. **OUT OF NETWORK:**

If we are "out-of-network" with your insurance carrier, we may still be able to work with your insurance to some degree to cover some of your health services. On the first few visits, an appropriate fee will be collected at the time of service from you towards your account. Once your insurance carrier provides us with an EOB (explanation of benefits) we will then "know" how they reimburse for your unique case. From there, we can specifically set your co-pay/co-insurance responsibility. You are responsible for any and all charges incurred at ParkView Health and Wellness Center on yours or your family members'
behalf. Your insurance policy will help with some of your responsibility, but not all of it. Thank you, in advance, for your understanding and compliance with this matter.

Terms of Service:

Whether you have coverage that is in or out-of-network, payments on any account balance is due within 30 days of receipt of your billing statement from ParkView Health & Wellness. If the balance on your account is

not paid within 30 days, it will begin to accrue interest at the rate of 1.5% per month. If any balance on your account is over 90 days past due, your account will be in default and may be referred to a collection agency.

FORMS OF PAYMENT:
We accept payment by cash, check, debit cards or credit cards (Visa, MasterCard, Discover and American Express).

RETURNED PAYMENTS:
If payment is returned or declined for any reason, your account may be charged a surcharge of $20.00 in addition to any costs assessed or charged by the bank or credit card service.

OTHER CHARGES:
Patients may incur and are responsible for the payment of additional charges at the discretion of ParkView Health and Wellness including but not limited to: charges for returned checks, charges for a missed appointment without 24 hour advanced notice, charges for extensive phone consultations and/or after-hours phone calls requiring the doctor's advice; charges for copying and distribution of patient medical records; charges for extensive forms preparation; or any costs associated with collection of patient balances, all as allowed by law.

COLLECTIONS:
Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account balance, please understand that ParkView Health & Wellness Center has the right to disclose to an outside collection agency or attorney all relevant personal and account information (not medical) necessary to collect payment for services rendered.
You are responsible for all costs of collection including, but not limited to: late fees, charges, and interest due as a result of such delinquency; all court costs and fees (but only to the extent allowed by law); and a collection fee to be charged under separate agreement with a third- party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. You acknowledge that any such interest assessed on the account will be a late fee as a result of default or delinquency on your account, and is not deemed interest as part of a credit transaction. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history.

COMMUNICATIONS:
You authorize ParkView Health & Wellness Center to communicate by mail, voicemail, and/or e-mail according to the information provided in your patient registration regarding financial responsibility only. ParkView Health & Wellness Center, it's authorized agents or service providers will have access to your patient financial information and we may contact you for purposes related to your account, including debt collection. You authorize ParkView Health & Wellness Center to use this information in any manner consistent with the information you have provided, including mail, telephone calls, voicemail, and e-mails.

By signing this Patient Responsibility Statement, you are agreeing to all the above statements.

_____ _____

Patient Signature/ Parent/ Guardian Date

Print Name_____

Patient Consent for use and or disclosure of protected health information to carry out treatment, payment, and healthcare operations.

Name _____

I hereby state that by the signing this Consent, I acknowledge and agree as follows*

1) The Practice's Privacy Notice has been provided to me prior to my signing the Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to the treatment to me, and also necessary to the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explains to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with the applicable law.

3) I understand that, and consent to, the following appointment reminder will be used by the Practice: a) a postcard mailed to me at the address provided by me: b) texting and c) telephoning my home and or cell phone, leaving a message, with the individual answering the phone.

4) The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific healthcare operations.

5) I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or healthcare operations. However, the Practice is not required to agree to any restrictions that I have requested. However, if the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6) I understand that this consent is valid until authorization is revoked or when minor becomes of legal age. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation will not apply to the extent that the Practice has already taken action in reliance on this consent.

7) I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.

8) I understand that if I do not sign this Consent evidencing my consent to the uses and disclosure described to me above the contained in the Privacy Notice, then the Practice will not treat me.

9) I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Signature _____ **Date** _____