Appledore
MEDICAL GROUP

PATIENT NAME_____DATE OF BIRTH_____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. **_____(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, **Appledore Medical Group** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. **_____(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that **Appledore Medical Group** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. **_____(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to **Appledore Medical Group** any insurance or other third-party benefits available for health care services provided to me. I understand **Appledore Medical Group** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Appledore Medical Group,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. **_____(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **Appledore Medical Group** by the Medicare or Medicaid program.

5. **_____(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for **Appledore Medical Group**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Appledore Medical Group** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **Appledore Medical Group** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. **_____(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify)_____

Appledore
MEDICAL GROUP

Financial Policy

Thank you for choosing us for your healthcare needs. Our goal is to provide and maintain a good physician-patient relationship. The following is our Financial Policy, which we ask you to review and sign prior to your first visit.

General Information

Your co-payment, deductable, coinsurance, or payment in full is due at time of service. We accept cash, check, American Express, Discover, MasterCard, and Visa. **Initial**_____

Regarding Insurance

Appledore providers participate in a wide variety of managed care plans. We are happy to bill your health insurance carrier as a courtesy to you. We suggest that all patients review their health coverage with their carrier prior to receiving services or treatment. It is the responsibility of the patient to notify us of any changes in the insurance policy. Your insurance policy is a contract between you and your insurance company and the Appledore staff will not know the terms of your insurance policy. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances. The patient/financial guardian will be responsible for any remaining balances. Additionally, it is your responsibility to obtain and track referrals for your visits.

Initial_____

Self-Pay Patients

Patients without health insurance are expected to pay at time of service. As a courtesy to these patients, we offer a 35% discount to most of the services rendered. If you are unable to pay the full balance at time of service the remaining balance is expected upon receipt of your first statement. **Initial**_____

Payment Arrangements

Appledore Medical Group can work out a payment plan for outstanding balances owed under certain circumstances of financial hardship. We are willing to meet with you to discuss your situation and try to work out a plan that will meet both your needs and the needs of Appledore Medical Group. Please consult with one of our billing staff for further information.

Initial_____

Worker's Compensation

Appledore will bill your employer's worker's compensation insurance carrier and follow all other procedures as required by the states workers compensation laws. As the patient, it is your responsibility to notify us prior to the visit that it is a work related case and to provide us with the appropriate worker's compensation policy information.

Initial_____

Automobile and Other Liability Cases

Due to State laws surrounding auto insurance payments, as well as payment delays, Appledore regrets that it may not be able to bill third party administrators in liability cases. In addition, we cannot suspend our normal billing and collection process when services are rendered. Your health insurance carrier or the guarantor will be billed for services. **Initial**_____

Returned Checks

There will be a $25 returned check fee on all returned checks. In the event that a check is returned for insufficient funds, we reserve the right to call your bank to verify funds for any future checks that are presented for payment on your account.

Initial_____

Missed Appointments

Unless cancelled at least 24 hours in advance your appointment could be considered a no-show. Our policy allows us to charge up to $25 for these types of missed appointments. Please help us serve you better by keeping your scheduled appointments.

Initial_____

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read, understand, and agree to this Financial Policy:

Patient Name _____ Date _____

Patient/Responsible Party Member's Signature _____

Responsible Party Member's Name _____Relationship_____

On completion, we will provide you with a copy for your records. ***12/2013***