Clarksville Internal Medicine, PLC.

Financial Responsibility Agreement & HIPPA Privacy Notice & Office Policy Agreement

I, ____________________ agree to the following:

- **Payment is expected prior to services rendered**. Payment may be made by cash, check, or major credit card. We collect previous balances, co-pays, deductibles, co-insurance for every provider's visit prior to being seen. If you do not pay the co-pay, co-insurances, deductible at the time of the visit there will be a $20 charge, unless payment plans have already been arranged.
  - As the undersigned I agree, whether signing as a patient or guarantor, to guarantee payment of the account in accordance to policies and terms of Clarksville Internal Medicine, PLC in Clarksville, Tennessee.
  - Self-Pay Policy • If you are a self-pay patient, you will be required to pay full charge for the office visit before services are rendered. • Any additional charges that occur during the visit, will need to be paid before test/ service is rendered or completed. We cannot bill you for any services.
  - I understand that my insurance, if any, is a contract of benefits between me and my insurance company; Clarksville Internal Medicine's only relationship is with you, the patient. Clarksville Internal Medicine, PLC will file your primary/secondary insurance for you, except for Medicare Advantage Plans.
  - Your insurance does not guarantee payment of the claim due to plan limitations and exclusions. You, as the beneficiary of the insurance policy, are responsible for knowing all policy limitations and exclusions of your plan. If the procedure or diagnosis is not covered by your plan due to a policy limitation or exclusion you will be responsible for any remaining charges incurred. Any discrepancies should be addressed with your insurance company as they make the final determination of benefits provided, not us. You are responsible for verifying that all waiting periods have been satisfied by your plan.
  - Insurance coverage will be verified at the time of service, if you have insurance coverage. You must provide this office with an insurance card or proof of coverage. If coverage is unable to be verified, you are responsible for all charges at the time of the visit.
  - Upon verification of insurance, we will estimate your portion of payment due**.** You are responsible for these charges and any other charges that incurred during that visit that could have not been estimated by us at the time of verification. You will be billed for the remaining amount/or can pay before you leave.
  - Your primary insurance will be filed by our office. If you have a secondary or supplemental insurance policy, it will be filed through our clearing house or crossed over from your primary insurance. Any remaining balances after your primary and secondary insurance pays will be your responsibility. **We will not file a third insurance**.
  - If you have a Medicare Advantage Plan, we will not file to a secondary insurance plan, you will be responsible for all charges (co-pays, co-insurances, deductibles) your Medicare Advantage plan does not cover. (This does not include traditional Medicare and a Supplement plan)
  - Insurance will only be filed for plans that we are provided with at the time of service. We will not "back file/retro-file" any claims or re-file any claims if correct information is not provided at the time of service. You are responsible for any of the charges that incurred due to incorrect information provided at the time of service.
  - This office will not be involved with any third-party liability cases. **We do not file with automobile or home owners insurance liability policies.** Full Charge for Services are to be paid by you and you can seek reimbursement from the liability insurance company.
  - **We are not a provider for Workers' Compensation Claims or Medical Care related to a work injury**. You have to see a Workers Compensation Provider for any issues related to your Workers' Compensation.
  - Your **balance is due upon receipt of our statement**. If not paid within 60 days billing, **Clarksville Internal Medicine, PLC reserves the right to charge a late fee of $10.00 per each visit for any balances due over 60 days.**
- In the event the charges incurred are not paid in full within 180 days, collection activity is instituted, whether by a collection agency or an attorney (or both), I agree to be responsible for and pay, in addition to the charges incurred, all costs associated with such collection activity including, but not limited to, reasonable collection fees, attorney fees, court costs, and contingent fees to collection agencies of not less than thirty-five percent (35%).
- Clarksville Internal Medicine, PLC reserves the right to transfer unpaid balances to outside entities for collection, such as banks or other financial institutions and who may report unpaid balances to credit bureaus.
- The provider has the right to terminate services/discharge you from the practice based on noncompliance of medical care, unpaid Financial Obligations, non-adherence or disagreement of Office Polices, Office Agreements and/or any reasons provider feels are disruptive to the clinic and/or jeopardizes the doctor/provider relationship.

Release of Information

I hereby authorize Clarksville Internal Medicine, PLC. to release all medical information (including, but not limited to information relating to mental health evaluation and treatment, sickle cell anemia, alcohol and drug abuse diagnosis and treatment, HIV status, AIDS or AIDS related diagnosis, if any such information exists) to all my agents, or the Social Security Administration, as may be required or requested for the processing of claims for insurance, social security, disability, or for other insurance purposes.

Medication History Consent

I give permission/consent to obtain all my medication/prescription history when reviewing and/or processing medications/prescriptions for my medical treatment.

Notice of Privacy Practice

I acknowledge receipt of the Notice of Privacy Practices (HIPAA). I have had the opportunity to review and consider the contents of the Notice of Privacy Practices. I understand that by signing below, I am giving my consent to your use and disclosure of my protected health information (PHI) and electronic PHI to carry out treatment, payment activities and healthcare operation, and have access to a copy of this office's Notice of Privacy Practices.

Authorization to Pay Insurance Benefits

I hereby authorize the payment of any insurance or other medical benefits directly to Clarksville Internal Medicine, PLC.

Office Policies

I have reviewed and understand the policies set by Clarksville Internal Medicine, PLC regarding "No Show" appointments and fees associated with "No Show" appointments, Prescription Refills, Payment Policies, Same Day Cancellations, Collection Policies, and any other policy set forth or amended by Clarksville Internal Medicine, PLC.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, OR HAS BEEN READ, THE FOREGOING, THAT HE/SHE UNDERSTANDS THE FOREGOING, THAT HE/SHE HAS RECEIVED A COPY/OR HAS ACCESS TO A COPY THEREOF, THAT HE/SHE HAS BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS THAT HE/SHE MAY HAVE CONCERNING THE FOREGOING, AND THAT HE/SHE IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT. THE UNDERSIGNED, HAVING READ AND UNDERSTOOD THE AGREEMENTS, ACCEPTS THE FINANCIAL RESPOSIBILITY AGREEMENT, THE RELEASE OF INFORMATION AGREEMENT, NOTICE OF PRIVACY PRACTICE, THE AUTHORIZATION TO PAY INSURANCE BENEFITS, THE AUTHORIZATION TO DEPOSIT CHECKS AND CLARKSKVILLE INTERNAL MEDICINE, PLC OFFICE POLICIES & AGREEMENTS.

Patient's Name (Please Print) Date

Patient's Signature Date

Responsible Person (Guarantor) Signature Date Relationship to Patient