JALH PHYSICIAN CLINICS

FINANCIAL POLICY

THANK YOU FOR CHOOSING JALH PHYSICIAN CLINICS/JENNINGS AMERICAN LEGION HOSPITAL AS YOUR HEALTHCARE PROVIDER. WE ARE COMMITTED TO YOUR TREATMENT BEING SUCCESSFUL. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS CONSIDERED PART OF YOUR TREATMENT. PAYMENT IS DUE AT THE TIME OF SERVICE. YOUR CO-PAY, CO-INSURANCE, AND DEDUCTIBLE IF APPLICABLE MUST BE PAID AT THE TIME OF YOUR VISIT. WE ACCEPT CASH, CHECKS, CREDIT CARDS, AND MONEY ORDERS. EXTENDED PAYMENTS, IF NECESSARY, MUST BE SET UP WITH THE OFFICE MANAGER PRIOR TO APPOINTMENT. OUTSTANDING BALANCES OF 120 DAYS OR MORE WHERE NO EFFORT HAS BEEN MADE TO CONTACT OUR OFFICE FOR PAYMENT ARRANGEMENTS COULD BE TURNED OVER TO AN OUTSIDE COLLECTION AGENCY. YOU WILL BE RESPONSIBLE FOR COLLECTION FEES.

WE WILL FILE YOUR INSURANCE CLAIM FOR YOU. WE ARE CONTRACTED WITH MOST INSURANCE PLANS AND IF WE ARE NOT, WE WILL DO OUR BEST TO ENROLL TO HELP IN YOUR TREATMENT. WE ACCEPT MEDICARE ASSIGNMENT, HOWEVER, YOU ARE RESPONSIBLE FOR YOUR DEDUCTIBLE EACH YEAR PLUS YOUR 20% IF NO SUPPLEMENTAL INSURANCE. WE WILL FILE YOUR SUPPLEMENT FOR YOU.

AUTHORIZATION

1. GENERAL CONSENT TO TREATMENT- I AGREE AND CONSENT TO MY PHYSICAL EXAMINATION BY MY PHYSICIAN/NURSE PRACTITIONER. I UNDERSTAND THAT ADDITIONAL DIAGNOSITC PROCEDURES AND TREATMENTS MAY BE RECOMMENDED BY THE PHYSICIAN OR NURSE PRACTITIONER AND WILL BE DISCUSSED WITH ME BEFORE BEING DONE. I ACKNOWLEDGE THAT THERE ARE NO GUARANTEES, EXPRESSED OR IMPLIED, AS TO THE RESULT OF ANY PROCEDURE OF MEDICAL TREATMENT.
2. RELEASE OF INFORMATION- I AUTHORIZE THE PHYSICIAN/NP PROVIDING SERVICES ON BEHALF OF THE PATIENT TO RELEASE ALL BILLING AND MEDICAL INFORMATION (INCLUDING INFORMATION CONCERNING SUBSTANCE ABUSE AND HIV STATUS, IF APPLICALBE) TO PHYSICIANS OR INSTITUTIONS PROVIDING FOLLOW-UP CARE, THE SOCIAL SECURITY ADMINISTRATION, MEDICARE, MEDICAID, AND THE INSURANCE COMPANY, HMO, EMPLOYER, PERSON ACTING ON BEHALF OF THE PREFERRED PROVIDER ARRANGMENT OR THIRD PARTY NAMED ON COMMUNICATION FORMS, WHEN SUCH INFORMATION IS REQUESTED FOR PAYMENT OR WORKERS COMPENSATION UTILIZATION REVIEW. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFECT UNLESS REVOKED BY ME IN WRITING AND DELIVERED TO THE OFFICE MANAGER
3. ASSIGNED OF INSURANCE OR THIRD PARTY COVERAGE- I AUTHORIZE ANY THIRD PARTY PAYER TO PAY DIRECTLY TO THE PHYSICIAN/NP PROVIDING THE SERVICE TO THE PATIENT, ALL BENEFITS DUE AND PAYABLE AS A RESULT OF SERVICES RENDERED.
4. ACKNOWLEDGMENT OF RESPONSIBILITY TO PAY FOR SERVICES- I UNDERSTAND, ACKNOWLEDGE, AND AGREE THAT, EXCEPT AS PROVIDED BY LAW, AND IN CONSIDERATION OF THE SERVICES PROVIDED, I WILL PAY ANY CHARGES WHICH FOR ANY REASON ARE NOT PAID BY ANY THRID PARTY PAYER UNLESS THERE IS A SPECIFIC WRITTEN AGREEMENT BETWEEN THE PHYSICIAN AND THE PATIENT OR BETWEEN PATIENT AND THE PAYER.
5. MEDICARE PATIENTS- I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS TO BE MADE TO MY PHYSICIAN/NP FOR ANY SERVICES FURNISHED TO ME BY THIS PROVIDER/NP. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE CENTE OF MEDICARE AND MEDICAID SERVICES AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THOSE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.
6. AUTHORIZATION AND RELEASE- INSURERS AND MANAGED CARE COMPANIES OCCSIONAL REVIEW MEDICAL CHARTS TO INSURANCE COMPLIANCE WITH COMPANY PROCEDURES. I UNDERSTAND THAT MY CHART MAY BE SELECTED FOR SUCH A REVIEW AND THAT THE CONFIDENTIALIT OF THE INFOMRATION IN MY CHART WILL BE PRESEVED AND I HEREBY CONSENT TO SUCH REVIEW AND RELEASE THE PHYSICIAN AND ANY SUCH INSURER OR MANAGED CARE COMPANY FOR LIABLILITY FOR ANY REASONABLE REVIEW OF MY CHART.

PRIVACY PRACTICES

YOU HAVE THE RIGHT TO READ OUR NOTICE OF PRIVACY PRCTICES BEFORE YOU DECIDE WHETHER TO SIGN THIS CONSENT. OUR NOTICE PROVIDES A DESCRIPTION OF OUR TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS, OF THE USES AND DISCLOSURES WE MAY MAKE OF YOUR PROTECTED HEALTH INFORMATION, AND OF OTHER IMPORTANT MATTERS ABOVE YOUR PROTECTED HEALTH INFORMATION. YOU MAY OBTAIN A COPY OF OUR PRIVACY PRACTICES AND ANY REVISIONS AT ANY TIME TO OUR OFFICE MANAGER. YOU HAVE A RIGHT TO REVOKE THIS CONSENT AT ANY TIME WITH WRITTEN NOTICE TO OUR OFFICE MANAGER.

I HAVE READ, UNDERSTAND, AND AGREE TO THE POLICIES ABOVE AND TO OUR PRIVACY PRACTICES:

PRINT NAME____

PATIENT OR GUARDIAN SIGNATURE____ DATE ___/____/_____