

Thank you for considering the DiabeVita Medical Center as your healthcare provider. We provide our services with care, pride and professionalism, and as with any business, we want the financial implications of our providing this service to you to be as clear as possible. Due to many changes in health care financial matters in recent years, you may find that some policies have changed from what you have been used to in the past. This form explains our very simple policies and expectations on billing, payments, and terms of service. Please review carefully to avoid possible misunderstandings between us later. We will gladly answer any questions you may have.

Payments for services

All financial arrangements must be made prior to rendering services. Co-pays and any outstanding balances for insured patients must be paid at check-in. Self-pay patients and insured patients with an open deductible at time of service must pay for the service in full before provided, or if the scope of service is unknown in advance, pay a deposit of at least \$125 to reasonably cover the expected service. Payments for any service or products may be made by cash, most major credit cards, debit cards and checks. Please note all checks are run through TeleCheck Services and may clear your account the same day as written.

Insured Patients

We will ask for your insurance card prior to or at each visit and collect your co-pay at check-in. We are required to verify coverage with your insurance company prior to rendering service at every visit. If current information is unavailable, or there is any uncertainty over coverage, we will collect payment from you and then provide you with the necessary forms to remit to your insurance company for reimbursement directly to you at your convenience. When applicable, we will file your claim and bill your insurance company as a courtesy, but you remain responsible for payment until we receive payment from your insurance company. It is not unusual for an insurance company to refuse to cover the service rendered as you expected. Your insurance policy is a contract between you and your insurance company, and we cannot get involved in disputes on such matters as deductibles, co-payments, or non-covered charges and rates. If your insurance company does not pay us within 60 days of filing your claim, you will be held responsible for payment.

Self-pay Accounts

Self-pay accounts are patients without verified coverage by insurance companies with which we are registered participants. We do not accept attorney letters or contingency payments on liability cases. We may collect a deposit of \$125 for all self pay accounts at check-in, and will reconcile with you at checkout for any additional charges or refunds due. We can provide a receipt for you to submit to any insurance company with which we do not participate

Minors and Wards

The parent(s) or guardian(s) for a child or ward must sign all financial obligation forms and is responsible for full payment. A signed release to treat may be required for unaccompanied minors.

Credit card charges for unpaid bills

If we have your credit or debit card information on file from a past payment, we may use that information to charge your credit card to pay for any past due balance on your account that may arise in the future. We will not do so without first extending an opportunity to you to contest the claimed amount; pay by some other means; or to make other arrangements. We will send you a confirmation notice if such action is taken.

Payment Plans

Under very limited circumstances, we may extend payment plan terms to you for certain procedures and treatments. An application is required, and decisions are made on a case-by-case basis by the Business Office. Any such arrangement must be made prior to us rendering services.



NEW PATIENT AUTHORIZATIONS AND ACKNOWLEDGEMENTS

PATIENT FULL NAME _____ DATE OF BIRTH _____

We are required to maintain records indicating that we have given you privacy and other information to review if you so desire, and must keep record of certain authorizations. Please read each of the following statements and initial each one. If there are any questions, please let us know. Thank you, and we look forward to working with you to achieve optimal health!

I have been given a business card, brochure, or other printed material with the DiabeVita Medical Center contact information, including phone and email address.

I have been given a copy or access to DiabeVita privacy policies pursuant to the Health Insurance Portability and Accountability Act of 1996 which state how DMC may use my personal health information. I authorize DiabeVita to contact me to remind me of an appointment, including by phone and/or by email, and to leave a message regarding my appointment on my voice mail if I am not available at the time of the reminder call. If I do not want a voice mail message left, I will advise DiabeVita in writing of this request.

I have reviewed DiabeVita's Financial Policies, including our requirement that all charges incurred not payable by insurance must be paid prior to or at time of service. I also understand that if for any reason my insurance company does not pay for a rendered service, I remain responsible for such billing. I authorize DiabeVita to charge my credit card it may have on file for any valid past due balances if, after notice, I do not make other payment arrangements when billed.

I have been given an opportunity to list my current and past medical condition and history on forms provided by DiabeVita, and that to the extent I chose to not answer fully or truthfully, DiabeVita is not liable for any errors or omissions in treatment that might arise from lack of accurate information as requested.

I understand that if I do not cancel a previously scheduled appointment within 24 hours of the appointment time, I will incur a \$25 Missed Appointment Fee.
