

Tallahassee Medical Group

FINANCIAL POLICY

- Payment is due at time of service:** We accept cash, check, or credit card for payment of our estimate of your patient responsibility at the time of service. We make every effort to identify in advance of your scheduled visit all amounts that are owed or will be owed as your portion of responsibility, including deductibles, co-pays, and co-insurances. Insurers however ultimately reserve the right to process our claims and notify us of their final determination of your individual responsibility through the claims filing process. Our initial determination of your portion of financial responsibility prior to your scheduled service is therefore strictly preliminary and may be subject to adjustment when claims are processed by the insurer. We will notify you via our patient statements as soon as possible if there are changes to your financial responsibility that have occurred during claims filing based on your insurer's final determination. If requested, an itemized listing of services provided will be given to you.
- **PATIENTS WITH HIGH DEDUCTIBLE HEALTH PLANS AND PRIVATE PAY PATIENTS: Please be prepared to pay your full charges prior to service. We reserve the right to reschedule or delay service if you are unable to make payment in full at the time of service.**
 - **Our Billing Services:** We will file charges on your behalf with most health plans. We are participating providers for most insurers in Tallahassee, but not all insurers – please refer to our website for a listing of our participation agreements with health plans. It is always a good idea to confirm your health plan information with your physician's office at the time of scheduling to ensure that there have been no changes in your coverage that might impact the filing and payment of your claims. **PLEASE NOTE TMG IS UNABLE TO BILL OR RECEIVE PAYMENT FROM ANY HMO PLANS UNLESS WE HAVE A SPECIFIC PARTICIPATION AGREEMENT WITH THE HMO PLAN. WE WILL BE UNABLE TO PROVIDE SERVICES TO YOU IF WE DO NOT HAVE A PARTICIPATION AGREEMENT WITH YOUR HMO.**
 - **Co-Pays, Deductibles, and Co-Insurances:** Your share of co-pays, deductibles, and co-insurance are your responsibility and payment are due at time of service. The portions of our charges that are your responsibility are based on your contract with your insurer and are your part of the contractual obligation directly to and with your insurer. Your insurer requires and expects that we will collect 100% of your financial responsibility under your contract. We are not permitted to waive or otherwise reduce this obligation on your behalf.
 - **Secondary Insurances:** If applicable, secondary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any secondary coverage that you have at the time of your appointment.
- Tertiary Insurance, if applicable:** Tertiary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any tertiary coverage that you have at time of the appointment.
- **Charges for missed appointments (generally termed "no-show fees"):** A **\$25.00** fee will apply if you fail to present to an appointment without notifying us at least 24 hours in advance:
 - **Statements:** We provide patient statements to our patients every month. The statements summarize the outstanding charges and claims activity. We expect payment of your statement balance in full upon your receipt of the statement. If you have a question or believe there is an error on your statement, or if you have any concern about your statement transactions, please contact us in a timely manner. We reserve the right to avoid the cost of sending statement to patient who have a small balance outstanding (usually less than \$5.00). Our front staff will collect the balance at your next office visit for small balances.
 - **Financial Promissory Agreement:** If you are unable to make payment in full for your portion of financial responsibility at time of service, you will be required to sign a **Financial Promissory Agreement** giving you 14 calendar days to submit payment in full. **If you do not make payment within 14 calendar days, we will assess an additional \$25.00 administrative fee to the original co-pay, deductible, or co-insurance due.**
 - **Collections:** If no payment is received within 90 days, your account is considered delinquent and may be referred to an outside collection agency. **Referral to outside collections may damage your credit, so we strongly urge you to contact our office to work out a payment arrangement in order to avoid this.**

*If you have questions or concerns about of Financial Policy procedures or fees your physician's office or billing department can help.

My signature below certifies that I have read, understand, and agree to the terms and conditions of this Financial Policy.

Patient Name (PLEASE PRINT): _____ Patient DOB _____/_____/_____

Patient Signature: _____

Patient's Communication Instructions, Patient's Release and Acknowledgement

Patient Name (PRINT): _____

Date of Birth: _____

Patient Address: _____

TELL US WHAT YOU WOULD LIKE TO AUTHORIZE OR LIMIT WITH THIS FORM (check all that apply):

- I would like to UPDATE or CHANGE my telephone number and/or email contact information
- I would like to AUTHORIZE or CHANGE MY AUTHORIZATION for certain individuals to have access to and/or receive communications and disclosures concerning my healthcare
- I would like to LIMIT or REVOKE my authorization for individuals that have previously had access to and/or received communications and disclosures concerning my healthcare

Which of the following communication means are appropriate/acceptable for our office to communicate with you? (Please check all that apply)

- Home phone number – leave message to return call – NO particulars NUMBER: _____
- Home phone number – leave message with particulars NUMBER: _____
- Cell number - leave message to return call – NO particulars NUMBER: _____
- Cell number – leave message with particulars NUMBER: _____
- I would like to receive text message for appointment reminders NUMBER: _____
- Email _____
(Please do not assume that email will be used by your physician for communication)

Who are you authorizing our office to discuss your health situation with? (Please list all names)

- Discuss with no one
- Second Parent: Circle AUTHORIZED or UNAUTHORIZED Name: _____
- Sibling: Circle AUTHORIZED or UNAUTHORIZED Name: _____
- Sibling: Circle AUTHORIZED or UNAUTHORIZED Name: _____
- Other Relative: Circle AUTHORIZED or UNAUTHORIZED Name: _____

Primary Language: _____ Other Language: _____

■ CASE OF EMERGENCY, OR IF WE ARE UNABLE TO REACH YOU, WHOM MAY WE CONTACT?

Name: _____ Relationship: _____ Phone: _____

This authorization will expire on: _____ (If no date is specified, it will expire upon your written amendment and instructions through your execution of a change to the information contained on this form via a completion of a new/replacement form).

Signature of Patient or Legal Guardian _____ Date _____

If not the patient, explain relationship and legal authority: _____

TALLAHASSEE PEDIATRICS

PATIENT'S NAME _____ PRIMARY PHONE # _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

MOTHER'S NAME _____ DOB _____ CONTACT PHONE # _____

FATHER'S NAME _____ DOB _____ CONTACT PHONE # _____

INSURANCE COMPANY _____

PRIMARY INSURANCE HOLDER _____

PLEASE LIST ALL CHILDREN WHO WILL BE OR ARE PATIENTS OF THIS PRACTICE

1. _____ M/F DOB _____
2. _____ M/F DOB _____
3. _____ M/F DOB _____
4. _____ M/F DOB _____
5. _____ M/F DOB _____

EMERGENCY CONTACT (OTHER THAN A PARENT LISTED ABOVE):

NAME _____ PHONE # _____ RELATIONSHIP _____

DO YOU HAVE SECONDARY INSURANCE?

COMPANY _____ POLICY # _____

I UNDERSTAND THAT TALLAHASSEE PEDIATRICS IS FILING MY INSURANCE AS A COURTESY. IF FOR ANY REASON MY INSURANCE DOES NOT PAY IN A TIMELY MANNER (90 DAYS OR LESS), I WILL BE RESPONSIBLE FOR PAYING THE BILL IN FULL FOR ANY OUTSTANDING BALANCE.

NAME _____ DATE _____

**PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND
TREATMENT AUTHORIZATION**

I understand that under Federal and State law I am entitled to have information regarding my physical and mental health condition and health care I have received remain private and confidential. Under certain circumstances Tallahassee Medical Group ("TMG") is limited in its ability to release such information, known as Protected Health Information, without my authorization.

I understand I have the right to review the Notice of Privacy Practices of Tallahassee Medical Group prior to signing this document, and I acknowledge that the TMG Notice of Privacy Practices, which includes a listing of my rights as a patient, has been provided to me. I understand that the Notice of Privacy Practices for Tallahassee Medical Group is also available on the website for TMG at www.TallahasseeMedicalGroup.com. I understand that my physician is a part of TMG, and that this notice applies to the protected health information that my physician, as a part of TMG, collects, receives, or creates for my past, present or future physical or mental health.

I hereby consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health-care bills, including my insurance carrier or health maintenance organization, to conduct healthcare operations of TMG, and/or any other permitted disclosure, as outlined in the Notice of Privacy Practices.

I also understand that TMG participates with and provides electronic medical records to certain health information exchanges. Information regarding health information exchanges, including as an example www.centralishealth.com is included on page 2 of this document. The information exchanged in these activities may include my protected health information. I hereby authorize such transmissions. **I understand that I may opt out of this transmission at any time by sending a written request specifically stating my desire to opt out of Centralis Health activities directly to our Privacy Officer at 1511 Surgeons Drive, Tallahassee, FL 32308.**

TMG reserves the right to revise, make new provisions and or change the terms of these notices at any time. New notices will be effective for all protected health information that we maintain at that time. Such revised notice will be made available to you by posting a copy of the revised notice on our website at www.TallahasseeMedicalGroup.com.

I hereby certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act by any third-party payors is correct. I assign payment to TMG of all benefits due by me under the terms of said policies and programs. I assign payment to the physician rendering medical services and the physician for whom the hospital is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles; coinsurance or any other charges incurred which are not paid by my insurers or other third-party payers together with all costs of collection, if necessary, including collection fees charged by a third-party collection agency and reasonable attorney's fees if collected by or through an attorney-at-law.

A PHOTOSTAT COPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

IMPORTANT INFORMATION RELATED TO HEALTH INFORMATION EXCHANGE

Important legislation in the American Recovery and Reinvestment Act of 2009, enacted by Congress, includes important provisions which impact health care providers and patients alike. Among the provisions of this Act is the concept of Health Information Exchange ("HIE").

Health information exchange (HIE) is defined as the mobilization of healthcare information electronically across organizations within a region or community. HIE provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care. HIE is also useful to Public Health authorities to assist in analyses of the health of the population.

Tallahassee Medical Group. participates in and provides patient information to HIE's in certain circumstances in order to facilitate the coordinated continuum and exchange of healthcare information between facilities and providers.

For the purpose of informing you, our patient, concerning HIE in general, and our participation in and commitment to HIE, we have included a brief explanation and an example of a local resource of HIE in Tallahassee through Centralis Health (www.centralishealth.com)

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Centralis Health is engaged to deliver easier ways to communicate information and share HIPAA-compliant medical correspondence between healthcare providers. From electronic faxing to intuitive interfacing and clinical data exchange, communications are electronically streamlined to reduce errors and increase staff and patient satisfaction. Unless you specifically opt out as provided below your personal health information will be provided to organizations such as Centralis Health under secure methods with HIPAA compliant agreements. Tallahassee Medical Group and our physicians support this health information exchange as an important part of healthcare technology that facilitates communication and community coordination of your patient care.

Clinical data exchange generally includes a group of organizations and stakeholders that exchanges data electronically in a manner that is fully HIPAA compliant technologically and controlled by HIPAA compliant agreements between the parties in order to improve the quality, safety, and efficiency of healthcare delivery.

Example information on this effort and participation can be found at www.centralishealth.com. Example information on HIE generally and the national efforts in that regard can be found at www.healthit.gov.

Patient name (Please Print): _____ Patient DOB: ____/____/____

Patient Signature: _____

Consent for Services of a Minor Child

In almost all cases, Tallahassee Medical Group (TMG) requires written consent from a parent(s) or legal guardian(s) in order to provide healthcare services at physician's offices for a minor child under the age of 18.

All parent(s) or guardian(s) are encouraged to attend all medical appointments at Tallahassee Medical Group, but we understand that isn't always possible. To avoid having to reschedule appointments when a parent(s) or guardian(s) is unable to attend, this consent form authorizing TMG and its medical professional to provide medical care must be signed by the appropriate person.

I, (We) _____ and _____ do hereby state that I am (we are) the parents or legal guardians of (child's name) _____, of minor age born on _____.

****Please Initial options below****

_____ (I) We authorize and consent to all professional services provided at or arranged within the primary care office and their ancillary department(s).

_____ (I) We authorize and consent to any medically necessary treatment within the primary care office only and not ancillary department(s).

_____ (I) We do not give consent for _____ (list specific test/services) services.

The below adults are authorized to seek medical care and/or ancillary services in place of the minor child's parent and/or legal guardian.

Name: _____ Relationship to minor: _____

Consent expires on: _____ (If not dated, then it will expire one year from signed date)

Patient name: Print: _____ Sign: _____

Parent/legal guardian name (if patient is of minor age): Print: _____ Sign: _____

Date: _____ Explain your relationship to patient: _____

Tallahassee Medical Group (TMG) does not discriminate on the basis of race, color, national origin, sex, age or disability in its health programs or activities.