Name: _____

DOB: _____

Patient Financial Policy and Agreement

Edinger Medical Group EMG is committed to serving your healthcare needs. Please understand that payment of your bill is considered part of your healthcare relationship with our medical group and providers. This document is Edinger Medical Group's Patient Financial Policy. EMG requires that you read, sign, and agree to this policy prior to receiving treatment.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

INSURANCE BILLING

Your insurance policy is a contract between you and your health insurance company. It is your responsibility to know your benefits and how they will apply to the treatment you receive. All patients are responsible for their co-payment, co-insurance, unmet deductible, and cost of non-covered services at the time of the visit.

Depending on whether you are an HMO, PPO or CASH patient, you will initial next to the statement below that applies to you. *

- ◯ I am an HMO patient.
- ◯ I am a PPO patient.
- ◯ I am a CASH patient.

CONTRACTED HMO PLANS: All copays must be satisfied at every visit. Due to contractual and uniform compliance issues with your insurance company, there are no exceptions to the policy of collecting co-pays at every visit. *

CONTRACTED PPO PLANS: We bill your insurance company as a courtesy. All co-pays, co-insurance unmet deductible, and cost of non-covered services will be collected at the time of the visit. Any remaining balances due after contract adjustments and health plan payments are your responsibility. You will receive a statement for this remaining financial responsibility. All patient balances are due within 30 days of our statement date. *

CASH PATIENTS: All services must be paid in full at the time of the visit/treatment. Our offices will provide you with an estimate of the cost of treatment before the visit. *

OUT OF NETWORK PLANS

For patients with plans with which we are Out of Network, our offices will provide you with an estimate of the cost of treatment before the visit.

PAST DUE ACCOUNT BALANCES

Patients with an outstanding balance deemed past due (90 days) must speak with an account representative prior to future appointments.

REPORTING OF DELIQUENT ACCOUNTS TO CREDIT AGENCIES

If a patient account balance becomes delinquent and the patient account is suspended, that delinquent balance will be reported to national credit agencies. This may affect your current and long-term credit status adversely. These delinquent balances will remain in effect with credit bureaus indefinitely in the future until your overdue balance is paid.

Name: _____
DOB: _____

RETURNED CHECKS
A $25.00 fee will be charged for any returned check.

OPEN PAYMENTS
The Open Payments database is a federal tool used to search for payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

To acknowledge that you have read and understood the statements above, initial here: *

Patient Financial Policy Agreement

| have read the above EMG Patient Financial Policy, agree to abide by it, and have provided EMG with true and correct insurance information. I will notify EMG of any change in my health insurance coverage. I assign any payment and/or benefit from my insurance carrier for these services to EMG. I further authorize the release of any medical records necessary for REPORTING OF DELIQUENT ACCOUNTS TO CREDIT AGENCIES If a patient account balance becomes delinquent and the patient account is suspended, that delinquent balance will be reported to national credit agencies. This may affect your current and long-term credit status adversely. These delinquent balances will remain in effect with credit bureaus indefinitely in the future until your overdue balance is paid. RETURNED CHECKS A $25.00 fee will be charged for any returned check. OPEN PAYMENTS The Open Payments database is a federal tool used to search for payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

To acknowledge that you have read and understood the statements above, initial here: * the adjudication and payment of claims or any authorizations for services or procedures rendered or to be rendered.

Signature *

Signer's Name * _____

Print Responsible Party Name

(If different from patient)

_____

Today's Date * _____