

FINANCIAL POLICY & AGREEMENT

Thank you for choosing **CAPITAL PRIMARY CARE, INC. AND CAPITAL PEDIATRIC CARE, INC.** for your healthcare needs, where our physicians and staff are committed to providing the quality medical care that you deserve. Following is a statement of our Financial Policy, which requires your agreement. Please read it and sign it, prior to treatment. Our Financial Policy applies to all services rendered by our physicians, whether inpatient or outpatient. In order for us to bill for our services, we must require the completion of this form once annually.

Practice Payment Policy Guidelines:

- **Patients/guardians are financially responsible for all charges, regardless of third-party involvement.**
- **Full payment is due at time of services, unless prior insurance billing arrangements have been made.**
- **Patients with insurance will be required to pay all ‘out-of-pocket’ financial obligations at time of service.**
- **We accept: Cash, Check, and the following credit cards: Visa / MasterCard and Discover**

Patient Responsibilities and Financial Policies:

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes (name, address, phone, insurance coverage, etc.), you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient’s immediate financial responsibility.

Know Your Insurance Coverage, Benefits and Referral Requirements: Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage(s), benefits and referral requirements to receive diagnostic and therapeutic services from our physicians. Patients are responsible for securing the necessary written referrals, pre-authorizations or pre-certifications from your primary care physician or health plan prior to services rendered. If we have not received the necessary authorizations prior to your appointment, the appointment will be rescheduled. Please, present your Insurance ID card to our staff upon registration for each office visit.

Prescription Monitoring Program: You allow your physician to access information from the Prescription Monitoring Program in the event it is necessary to validate the appropriate use of controlled substances for legitimate medical purposes while deterring the misuse, abuse, and diversion of controlled substances.

Self-Pay Patients: Patients without insurance coverage are expected to pay for services received in full at time of service, unless a satisfactory payment agreement has been arranged with our billing manager prior to services being rendered.

Patient with Private Insurance / Medicare Coverage: Our physicians participate with the Medicare Program, and all insurance providers; however, we do not accept Discount Plans. We will file claim(s) to the insurance companies, provided that you authorize the ‘assignment of benefits’ below for payment directly to our Practice. In accordance with your insurance plans, the practice will accept payment based on contractual agreements. Absent an insurance provider, the practice will expect full payment from the patient at time of service. Any coverage or payment dispute is a matter between the insurance policyholder and the insurance company.

Patient Payment Agreement:

I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, coinsurance, copayment, or services deemed as “non-covered” by my insurance carrier at the time of service. If my insurance has not paid on my account in 75 days, the outstanding services will become my responsibility for immediate payment (unless Medicare). Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, or non-payment at time of service and/or any other reason; I agree to pay all charges within 30 days of services rendered. I understand that failure to pay outstanding balances or make payment arrangements within 90 days will result in the amount due being considered delinquent and subject to legal action or assignment to a collection agency. I further understand that failure to pay delinquent accounts may result in a finance charge assessment of 1.75% per month / 21% APR, and the possible dismissal of the patient from the practices’ care. I agree to pay a \$25.00 returned check fee for each instrument tendered by me but returned to this facility. I agree to pay a \$5.00 billing fee for each payment, including co-payments and co-insurance, not made at time of visit. Copies of my medical records can be obtained with advanced written notice in accordance with the Privacy Rule and Code of Maryland, with an administration charge of \$10.00 and a per page charge of \$0.50 for the first 50 pages and \$0.25 per page thereafter, plus actual costs associated with postage expenses. Completion of special forms has a minimum charge of \$10.00 per form.

Authorization and Assignment of Insurance Benefits:

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual,

electronic or telephonic. I authorize the practice to apply for benefits for services rendered to myself or minor child under any health insurance policies providing benefits and do hereby also assign and authorize payment of benefits from my insurance company to the practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to the practice. I authorize the practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my benefits.

In consideration for medical services rendered, I acknowledge receiving notice of the financial policy and agree to pay for said medical services in accordance with the terms above. My signature below indicates that I have read and agree to the above policy.

Signature of: Patient / Responsible Party / Guardian

Date