FINANCIAL AND ADMINISTRATIVE POLICY

Thank you for choosing us as your health care provider.

The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

ACKNOWLEGEMENT AND AUTHORITY FOR TREATMENT AND PAYMENT: I consent to treatment as necessary or desirable to the care of the patient named, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory x-ray or other studies that may be used by the attending doctor, his/her nurse of qualified designate. I acknowledge and understand that I am ultimately responsible for all of my charges and services rendered to me. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate.

AUTHORIZATION TO OBTAIN INFORMATION: I, Authorized any physician, medical practitioner, hospital, other medical or medically related facility, insurance or related facility, insurance or reinsuring company, the Medical information Bureau, Inc., consumer reporting agency, or employer having information available as diagnosis, treatment and prognosis with respect to any physical or mental condition and =/or treatment of me and any other nonmedical information to give to the group policyholder, my employer, or its legal representative, any and all such information. I, Understand the information obtained by use of the authorization will be used to determine eligibility for insurance, and eligible for benefits under any exiting policy. Any information obtained will not be released by/to any person or organization except to the group policy holder, my organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of the Authorization. I AGREE that a photographic copy of this Authorization shall be valid as the original. I AGREE this Authorization shall be valid for one year from the date signed.

RETURN CHECK POLICY: PSA imposes a service charge for checks that are returned. The returned check fee is $35.00. We do not redeposit return checks. We receive a returned check; the check writer is notified and given 10 days to settle debt by cash, money order or credit card. If the debt is not paid in 15 days from the date of the letter, the check will be turned over for collections from the District Attorney's Office.

CANCELLATION POLICY: Effective May 1st, 2013, PSA will implement a "Missed Appointment" fee of $50.00 for New Patients, $25.00 for established patients, $50.00 for PFT's. We will make every attempt to contact you with a reminder of your appointment. If you are unable to keep your appointment, you will need to contact our office within 24 hours to reschedule. Our ability to accommodate urgent patients or work-in patients relies on our ability to predict our schedule. If your appointment is confirmed and you do not keep the appointment then, the cancellation fee will be charged in order to schedule your next appointment. These charges will not be submitted to your insurance. They are strictly due from you the patient.

In general, **you are responsible** for all services provided on the date of treatment. In the event that our physicians participate with, or choose to bill, your insurance**, your co-payments are expected the same day**. Once your insurance company has made payment, you will be responsible for any remaining unpaid charges including deductibles, co-insurance, co-payments or any balance designated by your insurance carrier.

Policy for Insurance Participants: If we are filing your insurance through a contracted plan, it is YOUR RESPONSIBILITY to notify the receptionist that you are on a certain plan and give your insurance card and/or referral, to the receptionist BEFORE SERVICES ARE RENDERED. Should you NOT have your insurance card and/or

referral with you at the time of service, you will be asked to reschedule your appointment for a time when you can bring your insurance care and/or referral. DEDUCTIBLES and CO-PAYMENTS will be collected at the time of visit, and we will bill your insurance for the balance under the plan provisions. We honor all our insurance contracts and take adjustments as we are instructed by our payers. After your insurance pays and the insurance company states that you still have a balance, you will be responsible for the balance.

Medicare: All of our physicians are participating providers with Medicare. All deductibles and co-insurances are collected after receipt of payment from Medicare and any supplemental carrier you may have. We accept assignment on covered Medicare charges. Twenty-percent (20% of Medicare Co0Insurance payments are expected at the time of service unless you have supplemental insurances). You are responsible by law to pay these fees.

Secondary Insurance: We will file claims on secondary insurance as a courtesy to the patient. If the secondary insurance has not paid with 60 days of filing, the patient will receive a statement and be responsible for the balance.

Balance Due: Balances on your account are payable within 30 days of receipt of the bill. Should it become necessary to use an outside collection attorney to obtain payment, reasonable and customary fees for collection services could be added to your outstanding balance.

Self-Pay/Uninsured: All un-insured patients must see someone from the Business Office prior to appointment. The patient will be expected to make payment in full for services rendered the day of visit.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES: I have reviewed the office Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature:_____________________________________ Date:____________________________

Print Name:____