FINANCIAL POLICY

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms:

Patient Responsibility/what payment is due/etc?

Some immediate payment may be expected at the time of service. Our office requires that a credit card be kept on file for payment of any co-payment, coinsurance, deductible, or charge that may not be covered by your health insurance. In the case of a patient balance that is not satisfied by a charge to my payment method, I understand that I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date. If the balance is not satisfied by the due date, the balance will be charged to the card on file. (________) Initial

Will you bill my insurance?

Insurance is a contract between you and your insurance company. In most cases, we are not a party to this contract. CLSC will bill your primary insurance company on your behalf as a courtesy to you. To properly bill your insurance company, we require that you disclose all insurance information, including **primary and secondary insurance**, as well as any changes in insurance information.

It is your responsibility to notify our office promptly of any patient information changes (i.e., address, name, insurance information) to facilitate appropriate billing for the services rendered to you. Failure to provide complete and accurate insurance information may result in the entire bill being categorized as a patient's responsibility.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. (________) Initial

Which plans do you contract with?

CLSC accepts most major insurance plans. However, with the frequent changes that happen in the insurance marketplace, it is a good idea for you to contact your insurance company prior to your appointment and verify if we are a participating provider as per your plan.

What if I have an HMO Plan?

If your insurance carrier is an HMO plan with which we participate, a CLSC provider must be selected as the Primary Care Physician (PCP) before services are rendered. If a CLSC provider is not selected as the PCP, you will be asked to update your PCP prior to your appointment and obtain a confirmation code. If you are unable to change your PCP, your appointment will be rescheduled.

If we don't participate with your HMO plan or your plan does not have an out-of-network option, we are unfortunately not able to see you for any services in our office unless you sign the **Election to Self-Pay for Services Agreement.**
(________) Initial

Will you verify my Insurance Coverage?

CLSC will verify your insurance coverage at the time your visit is scheduled. If your insurance coverage changes after you schedule your appointment, please notify us as soon as possible, before your visit. **If we are not able to confirm active coverage, you will be considered "self-pay."** (________) Initial

What if my plan does not contract with you?

If CLSC is not a provider under your insurance plan, you will be responsible for payment in full at the time of service. As a courtesy, however, we will file your initial insurance claim, and if not paid within 45 days, you will be responsible for the total bill. After your insurance company has processed your claims, any amount remaining as a credit balance will be refunded to you. Refund requests must be made within 90 days of service. (________) Initial

For any questions please contact our office at 954-418-1683.

Signature: ____ Date: _______________

Credit Card Authorization Form

CLSC requires that all patients provide a form of payment ("Card on File") for the portion of services that your insurance does not cover, but for which you are responsible. Your credit card information will be kept confidential and secure, and payments to your card are processed only after the claim has been filed and processed by your insurance carrier.

All patients except those listed below are required to provide a "Card on File". Exceptions:

- Medicare or Medicaid or dual coverage patients
- Self-pay-FFS or DOT patients when visit is paid in full at time of service

I,___________________________________ , authorize CLSC to capture my credit card information and to charge my credit card as payment for any balance put into the "patient responsibility" as a result of my insurance plan's deductible, co-insurance or co-payment.

We require that you provide a credit card when you check-in for your visit. The information will be held securely until your insurance has paid their share and notified us of any additional amount owed by you. At that time, we will notify you that your outstanding balance will be charged to your credit card ten (10) days from the date of the notice. I acknowledge that my card will be run for the amount indicated as patient responsibility for services rendered. We will send you a notification for the charge to the email on file. (____)

We will always work with you to resolve any issues and will refund you if we have made a billing error. We will only charge the amount that we are instructed by your insurance carrier to collect as part of patient responsibility on your EOB. The Billing Department can be reached at 954-418-1683. If you disagree with how your insurance carrier processed the claim you will need to contact their customer service department directly.

I understand and agree that this form is valid until I give a 30-day written notice to cancel the authorization to CLSC, Attn: Billing Dept., 4855 W Hillsboro Blvd, Suite B2, Coconut Creek, FL 33073 . Authorization for services already rendered cannot be canceled or refunded. I agree to notify the practice in writing of any changes in my payment or other information. (____)

I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form. (____)

Patient Name:____
Cardholder's Name (as shown on card):____
Card Type:____
Email Address:____

Cardholder Signature: ____
Date:____