REITER, HILL & JOHNSON
OF ADVANTIA

Financial Policy and Consent Form

This form confirms that you understand that the services provided are necessary and appropriate and advises you of your financial responsibility. You will authorize payment of medical benefits to Reiter & Hill, PLLC dba Reiter, Hill, Johnson & Nevin (RHJN) for all services provided.

RHJN may verify insurance coverage as a courtesy, however you or your legal representative are ultimately responsible for services provided. You should check with your insurance plan to determine if prescribed testing (lab, radiology, etc.) is covered under your policy. You should also check with your insurance plan for any applicable co-pays, deductibles, or co-insurances as they, or any remaining balances, will be due at the time of service. You are fully financially responsible for any balance resulting from your care at RHJN.

You will be billed directly by RHJN for any charges related to a cord blood collection, lab stat fee, meet and greet appointment, and FMLA/disability form completion that may be submitted to and denied by your insurance company for any reason.

We will send you a statement for any outstanding balances and payments are due upon receipt of the statement. Failure to pay in a timely manner may result in a referral to a collection agency and/or you may be discharged from the practice. Any outstanding balance after 90 days of the date of service may be referred to an outside collection agency and may be subject to a collection fee of up to 33%. In the event you are referred to a collection agency, you will be financially responsible for any collection fees incurred. In the event that your account is sent to collections, you will be required to pay a $250 deposit to return to the practice that will be refunded upon payment in full of the services provided.

You are responsible for providing RHJN with your current mailing address, telephone number(s) and insurance card(s) at the time services are rendered. If you cannot provide a copy of your current insurance card, or do not have sufficient insurance information, you will be considered a self-pay patient or your appointment may be rescheduled at the discretion of RHJN. If you provide incorrect or expired insurance information you assume full financial responsibility for all charges incurred.

If you do not have health insurance, you will be considered a self-pay patient and will be offered a 20% discount off the published practice fee for each service rendered. This amount will be due in full prior to your visit.

You will be charged a cancellation/no-show fee if you do not call to cancel/reschedule your appointment at least 24 hours before your scheduled appointment time with any provider or sonographer. You will be charged $100 for a missed procedure or surgery or $50 for any other missed appointment.

For some insurance carriers, only one obstetrical routine ultrasound per pregnancy may be covered. RHJN will typically offer 3 routine ultrasounds during a pregnancy: viability, ultrascreen and anatomy. If any of these are denied by your insurance for any reason, you will be responsible for all charges.

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If you have an annual wellness visit or exam but need additional services, you may be billed for those additional services – please refer to the document "Annual Wellness Exam" on our website.

Assignment of Benefits

I understand and agree that payment of authorized benefits under my insurance carrier(s) will be made to me or on my behalf to the provider for any services or supplies provided by RHJN. I authorize the release of any medical or other information necessary to process this insurance claim.

Consent to Treat

I voluntarily consent to care and treatment as the RHJN providers in their professional judgment deem necessary for my health and well-being. My consent includes, but is not limited to medical examinations, diagnostic testing, surgical procedures, ultrasounds, laboratory testing, and vaccinations.

Telemedicine

I consent to participate in any telemedicine/virtual visit that I request or initiate.

Consent to All

I understand and agree that RHJN may contact me using automated calls, emails and text messaging to my mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from RHJN.

I acknowledge I have received and agree to the terms of the consent forms for the email policy, the ultrasound informed consent, and the Notice of Privacy Practices (HIPAA). All policies can be located on our website under Patient Information. I am responsible for advising the practice regarding any changes I would like to make to either the email or HIPAA policy.

_____
Signature of Patient or Legal Guardian

_____ _____
Printed Name Date

02/01/2019