AALFA Family Clinic

Patient Financial Responsibility Agreement-

Please read the following notifications of the financial responsibilities associated with services rendered to you or a member of your family.

MEDICAL INSURANCE

- As a courtesy to you, we will gladly bill your insurance for services however, you, the patient, have a contract with your insurance carrier. We cannot guarantee that your insurance will cover our services. You are required to present your current insurance card and picture ID at the front desk at each visit so we can verify your current information. Please inform us of any and all insurance you possess, and of any recent changes. A**ll charges are ultimately your responsibility**, regardless of insurance coverage or payment problems. You are responsible for payment of any and all copayments, deductibles, coinsurance and out-of-pocket expenses incurred, including fees for services not covered under your insurance policy.
- All **Co-pays** assigned by your insurance company are due at the time of service. If you are unable to meet your payment obligations we can reschedule your appointment to a more suitable time.
- If you have an outstanding balance, or your insurance requires you to meet a deductible or to pay any type of co-insurance, you will be asked to go through our **Check-Out Process** and receive an estimate for services received at your visit. We will pre-authorize your patient payment on a credit card to streamline the billing process and make you aware of your upcoming charges.
- Additional Bills:
  - AALFA Family Clinic uses an outside laboratory –Quest Diagnostics, Health East or Allina– for processing various lab tests. You may receive an additional bill from these facilities for lab work.
  - If you schedule a physical or preventative exam, and you wish for the provider to address other concerns during that appointment, the additional services provided will be billed to your insurance. This could result in extra expenses to you, such as co-pays, labs, etc. You are responsible for all charges remaining after insurance has been processed.

SELF PAY FINANCIAL POLICY

- If you are a **Self-Pay** patient we will collect full payment at the time of service. We do offer a discount if you are an existing patient with us, provided your family has a zero balance. If you are unable to meet your payment obligations we can reschedule your appointment to a more suitable time. We appreciate your understanding.

PAYMENT METHODS

- AALFA Family Clinic accepts cash, checks, and major credit cards (VISA, MC, DISCOVER) for any amount greater than $10. **Charges under $10 must be paid in cash**. Patients are responsible for an additional payment of $35 for any returned funds.

WORKMAN'S COMP / MOTOR VEHICLE ACCIDENTS

- For Workman's Comp (WC) and Motor Vehicle Accident (MVA) visits **please provide us with complete information the day of your appointment or you will be required to pay cash.** This includes your employer's name, address and phone number, the appropriate insurance billing address, phone number and claim # (if assigned), and details regarding your claim and injury. If you do not have sufficient information it will be considered a self pay and you will be responsible for full payment of the claim. If claims are denied or protracted lawsuit involved, the patient must pay the account in full.

BALANCES DUE

- Payment programs are limited, but available if arranged and approved through our Billing Department. These payment programs and pay back times are set up based on dollar amounts. You will be required to pay half up front and payments for the remainder.
- If you have any previous balances with us please make arrangements to have them paid off in two months from the date of this signed agreement.
- All account balances over 30 days old, including all relevant personal and account information, will be sent to an outside collection agency. You will be responsible for all reasonable collections and attorney costs incurred. If your account is/was in Collection status or a bankruptcy is filed, we will ask for the balances to be resolved before any additional services can be provided. You will also be asked to pay in cash for any further visits.

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Acknowledgement of Receipt of *HIPAA Notice of Privacy Practices*

I, ____,
Print Patient Name
have received the *HIPAA Notice of Privacy Practices* from AALFA Family Clinic.
I have also received a Patient Information Packet which includes, but is not limited to, the HIPAA Notice, Patient Bill of Rights and Responsibilities, and other information regarding policies pertinent to my care at AALFA Family Clinic.

Initials ____________________

Patient Financial Responsibility Agreement

The undersigned hereby acknowledges to have received, read and agrees to the *Patient Financial Responsibility Agreement.* This agreement, which is also stated on the back of this sheet, explains the financial credit and payment policies of AALFA Family Clinic. These consents will remain in effect for 1 year from the date it was signed unless written notification is received in our office.

The patient or guardian, if patient is a minor, is responsible for full payment for all services received.

Signed: ____ **Date**: ___________
Patient / Guardian Signature

Authorization for Data Sharing Arrangement

I understand and agree that my insurance company may share my past, current and future health and account records with AALFA Family Clinic about services I have received from other care providers unrelated to AALFA Family Clinic. These records may be used by AALFA Family Clinic as needed to manage or coordinate my care and to improve the quality of that care.

___ My insurance company may **not** release any identifiable health records from providers unrelated to AALFA Family Clinic for the purposes described above.

Medical Home (Health Care Home-HCH) Authorization

AALFA Family Clinic is a Certified Health Care Home Facility. A Health Care Home is your primary site for care. This initiative is a way of delivering healthcare through a team approach that gives you access to all services and support you need. This team design facilitates your medical care between your Primary Provider, other Health Care Providers, staff, and may also include trusted family or friends involved in your healthcare.

I choose AALFA Family Clinic as my primary clinic Yes No

These consents will remain in effect for 1 year from the date that it was signed unless written notification is received in our office.

Signed: ____________________________________ Date: ____________
Patient / Guardian Signature

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