



Responsibility for Payment/Receipt of HIPAA Notice/Patient Communication

I understand that I am fully responsible for all fees due to Access Primary Care Physicians, Inc. or any associated medical provider (collectively referred to as the "Clinic") as a result of services I have received and that all fees are due and payable at the time of service unless Clinic agrees to accept assignment of my Medicare, Medicaid or other insurance benefits.

If I have insurance coverage other than Medicare:

I understand that assigning benefits to the Clinic and the filing of an insurance claim on my behalf is a courtesy to me and this is not absolving me of my responsibility to pay for services if the insurance company fails to pay for these services or if deductibles and/or co-pays are due. I understand that my insurance policy may not cover the full cost of services or may consider it an uncovered service or medically unnecessary, or I may not have coverage benefits for these services. I therefore agree to be responsible for those charges incurred, as well as for my co-pay and/or any deductible that has not been met.

I further understand that any verification of my insurance benefits by the Clinic is not a guarantee of payment by my insurance company. If my insurance company does not pay for the services I have received, or fails to pay within 60 days of service, I understand that the Clinic will bill me for these services and I agree to pay any amounts due within 10 days of receipt of a bill for these services. In addition, if a claim is filed on my behalf as an unassigned claim, then I will also be responsible for the difference between the amount paid by my insurance company and the actual charge for that service.

If I am covered under Medicare or a Medicare Advantage health plan:

I understand that I will be responsible for my co-pay and/or any deductible that has not been met either through my Medicare coverage or any supplemental policy that I may also have. In addition, if a claim is filed on my behalf as an unassigned claim, then I will also be responsible for the difference between the amount paid by Medicare and the actual charge for that service.

I further understand that I will be notified in advance by an Advanced Beneficiary Notice of Noncoverage if Medicare likely will not pay for items or services. I will then have the right to make an informed choice whether or not to receive the items or services. If I choose to receive the items or services, I am aware that I will be responsible for paying for such items or services.

I request that payment of authorized Medicare, Medicaid or other insurance benefits be made on my behalf to the Clinic for any services furnished to me subject to any regulations pertaining to their assignment of benefits. I authorize any holder of my medical information to release to the Centers for Medicare & Medicaid Services, Social Security Administration and its agents, intermediaries or carriers, or to any other third-party sources or insurance companies and its agents any information or documentation needed to determine these benefits or the benefits payable for related services. A copy of this authorization may be used in place of an original and this authorization shall remain in force until revoked by me in writing.

I certify that the insurance information given by me is current and accurate to the best of my knowledge and I understand and agree to abide by the terms outlined above.

I further acknowledge that I have received a copy of the Clinic's Notice of Privacy Practices.

I agree to receive appointment and treatment reminders via text and voicemail: YES NO

Patient Name (Please Print)

Date

Patient or Responsible Party Signature

Relationship to Patient

Reason Patient Cannot Sign (if applicable)