TRI-COUNTY FAMILY MEDICINE FINANCIAL POLICY INFORMATION

If you or your dependent needs medical services in New York State, you must give your permission. This authorization will allow us to provide the services for you or your dependent. In the case of an emergency, authorization is not necessary.

Upon arrival, please verify information with the medical secretary and report any change in address, phone number, insurance, marital status, etc. that may have occurred since your last visit. Feel free to report any complaint you may have about charges, services, or any inattention from our office personnel. We will do our best to correct it. Please help us to help you.

Our staff will be happy to discuss the charges for our services with you. We want our patients to understand our fees and be satisfied that they are reasonable and equitable. Co-Insurance/Co-Pay IS REQUIRED AT THE TIME OF VISIT. The charge statement you receive at the time of your visit serves as your receipt of payment, an indication of services rendered including diagnosis. Tri-County Family Medicine Program, Inc. strives to ensure that we accurately charge for every patient visit. Accordingly, our providers select a preliminary billing code at the conclusion of each patient visit. A certified coding professional may then review the billing code selected and adjust for medical necessity and accuracy. If a coding change is made, the fee paid on your date of service may be adjusted.

We participate with most insurances and bill the insurance directly for COVERED services. If you have a commercial insurance or employer's self-insured plans, we will bill the insurance directly. Your insurance policy is a contract between YOU and YOUR insurance company. We can't guarantee payment of your claim. If it is not paid, the insurance company should explain to **YOU** why it was rejected.

Certain forms regarding proof of disability require the evaluation of the patient's chart, answering questions and completing the form by the secretary and provider. There is a charge for this, and you will be notified of this prior to completing the form.

In the case of divorced/separated parents, it is Tri-County Family Medicine policy to bill the parent having legal custody of the children. Any financial arrangements are private agreements to which Tri-County Family Medicine is not a party.

MEDICAL RECORDS:

Your medical records are held in strictest confidence. Information will not be provided to third parties (attorney or insurance company except a Workmen's Compensation carrier) unless we have written authorization from you except as authorized under the authorization to release information. If you wish information about your condition to be provided to your attorney or to an insurance company, they should request the information in writing and provide us with the HIPAA authorization signed by you to do so. SINCE THE COPYING AND ORGANIZING OF INFORMATION TAKES TIME BY THE STAFF, WE MUST CHARGE FOR THIS. The charge will be $.75 per page as authorized by law.

ASSIGNMENT OF INSURANCE BENEFITS:

In consideration of services rendered, I hereby authorize Tri-County Family Medicine Program, Inc. to submit claims on my behalf to my insurance carrier and I ***IRREVOCABLY*** assign and transfer payment to Tri-County Family Medicine Program, Inc. all benefits payable for services rendered by Tri-County Family Medicine Program, Inc. Assignment and transfer shall be for the recovery of insurance payments but shall not be an obligation of Tri-County Family Medicine Program, Inc. to pursue any such right of recovery. A copy of the authorization shall be considered as effective and valid as the original.

Should my insurance claim be denied for lack of eligibility or termination of covered services, I will be held responsible and intend to make payment for any balance due.

AUTHORIZATION TO RELEASE INFORMATION:

Tri-County Family Medicine Program, Inc. is authorized to release to my insurance company (or to the employer if coverage is under a self-funded insurance plan) any of medical records pertaining to the services being billed on me or my dependent's behalf. A copy of this authorization shall be considered as effective as the original. I authorize the release of any medical information necessary to process insurance claims and/or comply with my health plan 3rd party audit requirements and I assign benefits (including Medicare) of such claims to Tri-County Family Medicine Program, Inc.

DISMISSAL POLICY:

I understand that I may be dismissed from care at Tri-County Family Medicine for abusive behavior to staff or other patients.

APPOINTMENT REMINDERS AND COMMUNICATIONS:

[ ] (Place an X or √) I authorize Tri-County Family Medicine Program, Inc. to contact me via email communications and/or the patient portal for appointment reminders, health reminders/information and for insurance and account details. I understand that I will be provided with a user name and password for the patient portal and will review and consent to portal use upon my first log in to the patient portal.

Email address:

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[ ] (Place an X or √) I authorize Tri-County Family Medicine Program, Inc. use of text messages from the practice at my cell phone for appointment reminders, health reminders/information and for insurance and account details.

We do not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I understand that this will apply to future notifications UNLESS I request a change in writing.

AUTHORIZATION TO OBTAIN EXTERNAL PRESCRIPTION HISTORY CONSENT:

Accurate prescription history reduces medication errors and enhances patient safety. By authorizing Tri-County Family Medicine Program, Inc. to view your external prescription history provides our staff with information about medications you are already taking to minimize the number of adverse drug events.

[ ] (Place an X or √) I authorize Tri-County Family Medicine Program, Inc. to request, view and use prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes. I understand this may include prescriptions back in time several years.

I Acknowledge That One Signature on the Electronic Signature Pad Indicates:

- I have read and understand the Financial Policy of Tri-County Family Medicine Program, Inc. above and agree with same and I acknowledge that I have read and have had the opportunity to receive a copy of the **Patient Bill of Rights, Patient Information Brochure and the HIPAA Notice of Privacy Practices.**

Date _____Patient/Parent Name (Printed) _____

Patient/Parent Signature _____

Date of Birth _____