Dos Palos Apex Health Center **Financial Policies**

We would like to thank you for choosing Dos Palos Apex Health Center as your medical provider. We have written this policy to keep you informed of our current financial policies.

No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with the Billing Manager or the Quality Manager. Our practice serves all patients regardless of inability to pay. Discounts for essential services are offered depending on family size and income. You may apply for a discount at the front desk.

Insurance: Although we are contracted with several insurance companies, it is your responsibility to make sure that our office is a contracted provider in your plan. It is also your responsibility to know your insurance benefits.

As a courtesy to our patients we will file insurance claims from our office. In order to do this we will require information from you. We will need all your demographic and insurance information prior to your appointment. We also request an update of this information every year (the beginning of the year) thereafter. We ask that at the time of your appointment you bring in your insurance card and photo ID as well as any other information that will assist in making sure your claim is filed correctly.

At the time of service, and if applicable, you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles, and non-covered services or items received. The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. For your convenience, we accept cash, checks and credit cards (Visa and Mastercard), and money orders. Payments are also accepted by phone.

Statement to Permit Payment of Medicare Benefits to Rural Health Clinic: I request payment of authorized Medicare benefits on my behalf for any services furnished by Dos Palos Apex Health Center, Inc. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits for related service.

Auto Accident/Liability Injury: If your injury is a result of a motor vehicle accident, we will file claims on your behalf with your auto insurance company, only if you have medical payments on your policy. If your injury is a result from another party's negligence, you are required to pay for service and then collect from the responsible party. We will not file your insurance but will provide you a receipt to do so. We regret any inconvenience this may cause.

Worker's Compensation: If your injury is due to an accident in your work place, please inform the receptionist immediately. We are not authorized to treat you for this type of claim. You will need to contact your employer for instructions on how to file a worker's compensation claim. We regret any inconvenience this may cause.

Medical Records: We will provide you a copy of your medical records upon request and for a fee of $20.00. You will need to sign a letter of release prior to having them copied. Please allow up to 30 days for this request to be processed.

Billing: If you receive a bill from our office, it is because your insurance has stated the balance is your responsibility. Please contact our billing department if you have any questions about your bill. If you cannot pay the entire balance in full, please call to make payment arrangements.

Collections: Accounts that are not paid in full within 30 days begin our in-house collection process. If your balance becomes 90 days old, your doctor will be notified and you may be subject to dismissal from the practice and further collection activity from an outside collection agency.

Acknowledgement:

I acknowledge that I have received and read a copy of the **Dos Palos Apex Health Center office and financial policies.**

Signature of Patient or Guardian **Date** **Witness**

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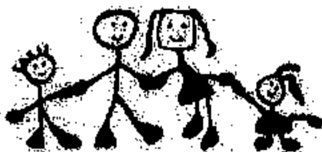

DOS PALOS APEX HEALTH CENTER, INC.
1549 Golden Gate Street, Dos Palos, CA 93620
Phone: (209)392-0022
Fax:(209)392-0011

Patient Name:______________________________ Medicare#:______________________

Medicare Secondary Payer Screening Questionnaire

Employment

1. Are you **currently employed** and covered by a group health plan? Yes No

2. Are you **covered by any active group health plan** through your spouse or family member? Yes No

Accidents

3. Is your visit today associated with a **work injury or illness,** either past or present? Yes No

4. Is your visit today associated with an **automobile vehicle accident?** Yes No

5. Is your visit today associated with an **accident other than a vehicle?** Yes No

Entitlements

6. Are you entitled to **Black Lung** benefits? Yes No

7. Are you entitled to Medicare **solely** because of **SSA Disability?** Yes No

8. Are you entitled to Medicare **solely** because of **End Stage Renal Disease?** Yes No

9. Are you enrolled in the **VA Fee Basis Program?** Yes No

Authorization Statement and Payment Agreement

I declare under penalty of perjury that I do not have another primary insurance carrier to pay for medical care rendered to me by Apex Medical Group, and that all information with regard to residence, employment, and income is correct to the best of my knowledge.

I request that payment of Medicare Benefits be made to this health care center for any services furnished to me by its physicians or suppliers.

I understand that my signature requests that payment be made and that it authorizes release of medical information necessary to pay the claim(s). If a secondary insurance carrier is involved my signature also authorizes releasing information to the insurer or agency shown.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determined by Medicare Carrier as full charge, and the patient is responsible only for the deductible coinsurance and non-covered services. Coinsurance and deductible are based upon charge determined by the Medicare carrier.

______________________________ ______________________

Signature of Patient or Authorized Representative Date

______________________________ ______________________

Witness Date

Dos Palos Apex Health Center, Inc.
1549 Golden Gate St. Dos Palos, CA. 93620
Phone: (209)392-0022

LIFETIME SIGNATURE AUTHORIZATION FORM

Name of Beneficiary:____________________________________

Medicare Number:______________________________________

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Apex Medical Group for any services furnished me by Apex Medical Group. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If item 9 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer of agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-inusurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature:____

Date:______________________________________