Kelsey-Seybold Clinic

AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby authorize the physicians of Kelsey-Seybold Medical Group, P.A. and affiliated or other providers to release information acquired in the course of my treatment to my insurance company, employer based health plan, or third-party payer as required of claims filed, quality assurance, health plan administration, complaints/grievances.

I authorize direct payment to be made to the physicians of Kelsey-Seybold Clinic Medical Group, P.A. or other providers for any and all medical and surgical services rendered. I understand that I am responsible for all charges if any services are not covered by insurance or if Kelsey-Seybold is unable to verify eligibility. I grant Kelsey-Seybold Clinic the rights to coordinate benefits with other insurance coverage and to collect against another party for reimbursement of expenses, if my injury or illness was caused by or is reimbursable by that party. I authorize Kelsey-Seybold Clinic to leave appointment and payment reminders on telephone answering devices. I understand that some physicians who are not employed by Kelsey-Seybold (who can be identified by their badges) may provide services at a Kelsey-Seybold location.

Financial Policy

Thank you for choosing Kelsey-Seybold Clinic for your health care needs. Please carefully review our financial policy. A customer service representative in our business office is available to answer any questions you may have regarding our financial policy or your payment responsibilities. They can be reached at 713-442-5500. Our office is open Monday – Friday from 8 AM to 5 PM.

Insurance Services

The Clinic participates with many health plans. As a courtesy to our patients, we will file claims with these companies. It is ultimately your responsibility for the full and timely payment of your account.

Please be prepared to submit your current insurance card at each visit. A scanned copy of this card may be kept as a part of your permanent record. You may also be asked for photo identification. Please also provide the clinic with up to date contact information including your home address, telephone number, and emergency contact information.

The Clinic will attempt to verify coverage and benefits prior to your visit with the physician. If we are unable to obtain a verification of coverage you may be asked to pay in full or reschedule your visit at a time the verification can be obtained. This verification will be used to estimate your financial responsibility; however, this verification is not a guarantee by your health plan of coverage or payment.

Payment of your estimated patient liability is expected at the time services are rendered. This payment will include known deductibles, copays, and coinsurance due for this visit. While we may estimate your financial responsibility, it is your insurance company that makes the final determination regarding your eligibility and benefits.

Please be aware that certain office procedures or services may not be covered, or may be considered "not medically necessary", "experimental", or "cosmetic" by your health plan. You are responsible for payment of these services. Please also be aware that many health plans limit preventative / annual coverage. In the event your care exceeds a plan limitation, you will be responsible for the balance. ***It is your responsibility to know the benefits and limitations of your current health care coverage.*** Kelsey-Seybold Clinic will provide medically necessary care based on patients' medical needs, not a patient's

insurance coverage. **Your Physician is not responsible for knowing your plan's specific benefit and coverage limitations**.

Please be aware that additional charges may be incurred if during the course of a physical exam the physician addresses, diagnoses or treats a problem-focused health concern.

Obstetrical and surgical patients will be asked to pre-pay all copays, deductibles, and coinsurance. Patients receiving cosmetic services, hearing aids, or contact lenses will also be responsible for paying in full before receiving services.

Kelsey-Seybold Ambulatory Surgery Center patients seen by Clinic physicians agree to the transfer of credit balances between these separately taxable entities in the event that a balance is owed to either entity.

The Clinic does not submit claims to non-contracted Third Parties involving automobile accidents and accidental injury. An itemized statement may be obtained by calling our business office. This statement will assist you with reimbursement. It is your responsibility to file claims in these instances.

Failure to Cancel Appointment/No Shows
The Clinic may charge tiered fees based on type of visit for failure to arrive at scheduled appointments.

Past Due Accounts
If your account becomes past due we will take necessary steps to collect this debt. Referral to a collection agency may adversely impact your credit record. Accounts turned over to collection agencies may also result in you being dismissed for non-payment as a patient from Kelsey-Seybold.

NSF Checks / Denied Credit Card Payments
If a check is returned for insufficient funds, account closed, or payment is stopped, your account will be charged a fee. This fee applies to payments made at our front desk, mailed in to the Business Office, electronically via the internet, or payments by phone. In the unlikely event that this happens 3 times, you will be required to pay by cash or preapproved credit card. We will be unable to accept checks or credit cards from you.

Self Pay Discounts
As a courtesy, the clinic offers a discount to uninsured and underinsured patient**s** for certain medically necessary services. This discount only applies to balances paid in full at the time of service. Some services, e.g., eye refractions, cosmetic services, and contact lenses may not be discounted.

Again, thank you for choosing Kelsey-Seybold Clinic. We appreciate the opportunity to serve you.

I acknowledge receipt of Kelsey-Seybold's Financial Policy. I acknowledge prior receipt of a Notice of Privacy Practices and that no warranty or guarantee has been made to me as to result or cure. I certify that I understand this statement.

Date:
Patient Name:
Signature: