Myrtle Beach Family Medicine, PA
Financial Policy

1. Payment for all services by Myrtle Beach Family Medicine [MBFM] is due in full at the time the services are rendered. Exclusions to this policy includes those patients who are members of a healthcare organization with which MBFM participates.
2. If you are a member of a healthcare organization that MBFM participates with, we will file your visit and your co-payment is expected at the time of service. If your insurance is one that we do not contract with, you will be given appropriate receipts for you to file with your insurance for direct reimbursement to you.
3. Medicare patients are responsible for their co-insurance, deductible and any services deemed Medically Unnecessary by Medicare. If there are any services that Medicare or other insurance companies deem NOT Medically Necessary or non-covered services, you will be held responsible for this cost.
4. Patients will receive a monthly statement itemizing the services rendered, claims submitted on their behalf, payments received and appropriate balance due. All patient balances are payable in full 15 days after receipt of the statement.
5. MBFM does not get involved with divorce or separation. For any patient 18 years or younger, the parent who accompanies the minor for their visit will be financially responsible for all charges incurred. Any patient older than 18 years will be financially responsible for all charges incurred.
6. In the event you are hospitalized, MBFM will bill all services rendered by our physicians in relation to the hospitalization with your health plan if we are a contracted provider. If we are not, we will provide the patient with forms necessary for them to file their insurance. Any services rendered by the hospital or it's staff will be billed separately by the hospital.
7. MBFM accepts cash, personal checks, money orders, travelers checks, MasterCard, Visa, American Express or Discover as payment for services rendered. A $30.00 service charge will be added to any non-paid or returned checks.
8. MBFM reserves the right to turn any patient over to a collection agency if it is deemed that the account has been in default of the payment obligations or compliance of this policy. 40% of your account balance may be added to your account for processing if this action is taken. Patient is responsible for any attorney or legal fees. I understand the collection agency may use automated services such as phone calls, etc.
9. In the event that you are unable to make your scheduled appointment, please cancel at least 24 hours in advance or a charge may be added to your account.
10. A $10.00 fee will be charged for any prescriptions without an appointment or calls requiring a medical decision.
11. In accordance with Title 45, Section 164.524(c)(4) of the code of Federal Regulations, we will charge for copying and mailing medical records if not related to treatment or referral by this office.

I have read and understand the above Financial Policy of MBFM. I agree to the terms outlined in this policy and understand that if I do not adhere to this policy, I may be turned over to a collection agency for non-payment of debt.

_____ _____

Signature of Patient/Responsible Party Date

Myrtle Beach Family Medicine, PA

Patient Consent for MBFM to Use/Disclose Protected Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Myrtle Beach Family Medicine [MBFM] originates and maintains electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
- A means for MBFM to treat me and refer me to any specialist as physician feels necessary and medical information needed to another physician who MBFM has referred me.

I understand and have been provided a *Privacy Notice* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that MBFM is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that MBFM reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should MBFM change their notice, they will post changed notice and/or provide me with a copy of the revised Privacy Notice.

I wish to have the following restrictions added to the use or disclosure of my health information:

[] No restrictions

[] Restrictions (Treatment, Payment, Healthcare Operations).Must be specific and list if any restrictions given:_____(Must be approved by MBFM)

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

[] Yes [] No I authorize MBFM to call my home or telephone number I've provided and leave a message.

[] Yes [] No I authorize MBFM to call me via cell phone *(understanding wireless privacy cannot be guaranteed. Also includes on-call physician who may return night or weekend calls.)*

[] Yes [] No I authorize MBFM to send mail to address I've provided in my medical record.

[] Yes [] No I authorize MBFM to communicate with me electronically (normally email).

[] Yes [] No I authorize MBFM to communicate with pharmacies verbally and electronically.

[] Yes [] No I authorize MBFM to make contact with family/significant others as listed below:

Name:_____Tel#_____Relationship_____

Name:_____Tel#_____Relationship_____

Name:_____Tel#_____Relationship_____

I understand and accept the terms of this consent:

_____

Patient's Signature Date

Office Use:

[] Consent received by:_____

[] Consent added to M/R on_____