FINANCIAL POLICY

Wellspire Medical Group (Wellspire) is committed to providing you with quality care. Your clear understanding of our financial policy is important to our professional relationship. To assist us in this, please provide:

- All necessary information for the billing of your claim, including your insurance card, employer information and demographic information.
- Satisfy all insurance co-payments, deductibles and non-covered services on the day services are rendered.
- Provide your insurance company and Wellspire with any additional information requested to complete the processing of claims filed on your behalf.

INSURANCE
Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable and customary" charges other than to supply the factual information as necessary. You are responsible for timely payments of your account. Wellspire Medical Group is filing your claim as a courtesy. This does not relieve you of financial responsibility of non-covered services or supplies.

WORKER'S COMPENSATION AND MOTOR VEHICLE ACCIDENTS
Wellspire does not file Worker's Compensation or insurance for motor vehicle accidents. You will be expected to pay by cash or credit card. *Checks are not accepted for Worker's Compensation or motor vehicle accidents.*

CONTRACTED MANAGED CARE PLANS (HMO, PPO, POS, EPO) AND REFERRALS POLICY
Each time you make an appointment with a Wellspire physician, it is your responsibility to make sure he/she is currently under contract with your managed care plan. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan. *Please plan to show you current insurance card at each visit.*

If you are referred to a specialist or decide you need a specialist, you may be required by your managed care plan to call your Primary Care Physician in order to obtain an insurance referral. It is your responsibility to keep track of the *expiration dates* and for giving your doctor's office a minimum of 72-hours' notice before being seen by a specialist. If you allow the referral to expire without use, Wellspire charges a $15 fee to process a new referral. Retro referrals may not be allowed on all managed care plans. Therefore, if a referral is not obtained, you may be held responsible for payment in full by the specialist.

DISABILITY, INSURANCE FORMS, AND MEDICAL RECORDS
There is a $25 dollar per form charge to fill out disability, FMLA, and other health related forms. Please mail or leave forms at the front desk with your payment. Forms will not be completed until payment is received. Please allow at least 3-5 business days for processing. You will receive a phone call once completed to pick up your form. *We will not mail or fax these forms.*

The cost of medical records are dictated by state and federal statutes. A list of fees will be given upon request.

YOUR SIGNATURE BELOW INDICATES:

- I have read and understand that I am personally responsible for payment on this account.
- In the event my insurance company deems a service to be "non-covered" I understand that I am personally responsible for payment.
- We do not file Medicaid insurance.
- *I understand that this practice has a no-show appointment fee of $25 for primary care physicians and $50 for specialists. I am responsible for paying the fee if I do not cancel an appointment with 24 hours notice.*
- I understand and agree that Wellspire may use and disclose my private healthcare information (PHI) to obtain payment from my insurance company or a third party. Wellspire may also disclose my PHI to your other health care providers to assist those providers in obtaining payment from my insurance company or a third party.
- I hereby authorize payment directly to Wellspire Medical Group. Any changes to this authorization must be received in writing within thirty days of effective date.

Guarantor Signature:_____ Date:_____

Guarantor Printed Name:_____ Guarantor Date of Birth:_____

Relationship to Patient:_____

Patient Name:_____ Date of Birth:_____