FREEPORT
OSTEOPATHIC HEALTH

FINANCIAL POLICY

We would like to thank you for choosing Freeport Osteopathic Health for your osteopathic care. Please note that we are a specialty office. Freeport Osteopathic Health participates with most major health plans and government agencies and assumes assignment of all benefits. Our billing office will submit claims for services rendered and will assist you in any way we reasonably can to help get your claims paid. However, often your insurance company may need you to supply certain information. It is your responsibility to comply with their request. Medical services that are non-covered or out-of-network, will be your financial responsibility. Should you experience a coverage or Primary Care Physician change please notify us at your next scheduled visit.

Your insurance company requires us to collect co-pays at time of service. We accept cash, checks, debit card and most major credit cards. Additionally, most insurance plans now have deductibles and co-insurance amounts due. Any outstanding balance on your account will be billed to you and due upon receipt of our statement. Statements are mailed to you monthly.

If you are presenting with a workers compensation injury, auto accident or other third party liability claim, you will be asked for the name of the insurance company, claims mailing address, insurance adjuster, and date of injury and authorization for services.

For our patients under the age of 18, if the child is arriving at the office without a parent, please remember that co-pays are due and make arrangements for this payment. You may call the office with payment or send payment directly with the child.

It is the policy of the practice to treat all patients in an equitable fashion related to account balances. The practice will not waive or fail to collect co-payments, co-insurances, deductibles or other financial responsibility in accordance with state and/or federal law and participating agreements with payers. Please let us know if you are having difficulty paying an amount due. We may be able to help you set up a payment plan.

A patient with a delinquent balance may be required to pay before ongoing services are rendered. Any amount in excess of 60 days past due is considered delinquent. An amount owed over 90 days past due may be referred to a collection agency.

I have read and understand the payment policy of Freeport Osteopathic Health and agree to abide by its guidelines:

___________________________________ __________________
Signature of Patient / Guarantor Date

____
Print Name of Patient and / or Guarantor

FREEPORT OSTEOPATHIC HEALTH
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GENERAL CONSENT FOR TREATMENT
&
PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

GENERAL CONSENT FOR TREATMENT

- I, the undersigned, being either the patient or their legally authorized representative, do hereby consent to routine medical and osteopathic manipulative treatment and/or evaluation, including but not limited to laboratory and x-ray examinations.

Patient / Guarantor Name: ___________________________________ Date: _________________

Patient / Guarantor Signature: ____

PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly

- Obtain payment from third party payers (payment)

I acknowledge that I have had the opportunity to review your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand the practice has the right to change its Notice of Privacy Practices from time to time and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment and operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by the restrictions.

Patient / Guarantor Name: ___________________________________ Date: _________________

Patient / Guarantor Signature: ____

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