MERIDIAN HEALTH Services

MERIDIAN HEALTH SERVICES FINANCIAL AGREEMENT/FINANCIAL POLICY

Patient Name: _____ **DOB:** _____

The following is summary of our financial policies for Meridian Health Services. **Payment is expected at the time of service** unless other arrangements have been made prior to the service. This includes applicable co- payments, deductibles, and other fees the patient is "responsible" to pay. For your convenience, we accept cash, checks, money orders, debit cards, MasterCard and Visa. We also offer monthly payment plans if needed. Patients are eligible to apply for discounted fees based on their income. Discounts are provided during the first **14 days** of treatment based upon stated income, but verification of income must be provided within **14 days** of registration (and every 6 months thereafter) in order to receive discounted services after **14 days**.

At least a minimum payment of $10.00 has been established for all services *Initials* _____

Patients with Medicare, Medicaid, or Managed Care insurance policies pay in accordance with the laws or contracts governing those plans. It is the patient's responsibility to bring to our office his/her insurance card and insurance information. Failure to provide insurance information or to assign benefits to the center will void any fee adjustment agreements.

Patients with outstanding balances must make arrangements and sign a payment agreement prior to continuing with or re-engaging in services. Patients with balances over 60 days (without prior payment arrangements and/or payments) will be subject to collection review and/or possible termination of services. Outstanding balances will need to be paid in full before you will be eligible for further services. This includes previous balances that have already been turned over to a collection agency. If a patient fails to meet any payment responsibilities, the patient will be responsible for all collection agency fees and reasonable attorney fees incurred by Meridian Health Services.

In the case of uninsured or under insured patients, Meridian Health Services will make every reasonable effort to assist the patient to make financial arrangements for the services received in accordance with the established center procedures which shall take in account the patient's gross family income and number of dependents as primary variables.

INCOME (use gross annual amounts):

(1) Wages, Tips, etc. (relationship)_____ $_____
(2) Wages, Tips, etc. (relationship)_____ $_____
(3) Business/Farm Income $_____
(4) Alimony $_____
(5) Unemployment/Workman's Compensation $_____
(6) SSI/SSDI Disability (relationship)_____ $_____
(7) SSI/SSDI Disability (relationship)_____ $_____
(8) ADC/Welfare/TANF $_____
(9) Pension $_____
(10) Other_____ $_____

TOTAL GROSS YEARLY INCOME $_____ **# of Dependent Children** _____
Total # of Persons Supported by Income Amount: _____ Food Stamps_____Yes_____No

TANF Eligible_____Yes (but not enrolled)_____No_____Enrolled HAP Eligible_____Yes_____No
SSI ____Yes ____No SSDI ____Yes ____No

Patient Name: _____ **DOB:** _____

I certify that the above information is accurate and acknowledge that verification of income will be required within **14 days** in order to continue to qualify for a subsidy. I further agree to notify MERIDIAN HEALTH SERVICES of any changes in this information during the course of treatment. Based on the above information you qualify for package subsidy. Package A requires a minimum fee of $10.00 for ***all charges that are not satisfied by insurance benefits or other third party coverage***.

The subsidy portion of the financial policy shall apply to eligible individuals based on established guidelines, i.e., those with no or inadequate means of paying for needed care. All fee adjustment subsidies are secondary to all other financial resources available to the patient, including group or individual medical plans, workers compensation, Medicare, Medicaid, other medical assistance programs, other state, federal, or military programs, third party liability situations (e.g., auto accident or personal injury), or any other situation in which another person or entity may have a legal responsibility to pay for clinic services.

Patients who have applied for Medicaid will be responsible for all services rendered until Medicaid coverage is approved. As mentioned above, a minimum payment of $10.00 is required for all services and a payment is expected for all services rendered at the time of service until Medicaid is approved. You will not receive a statement unless Medicaid coverage is denied. If Medicaid is approved, a refund will be issued for payments made if all other outstanding balances have been paid in full.

In the instances when a patient fails to notify the center of a cancellation at least twenty-four (24) hours in advance, the recipient may be charged and billed the center's established minimum charge of $15 or an amount not to exceed 50% of the charge she/he would have incurred had the appointment been kept, whichever is greater. Two or more "No Shows" could result in the patient being released from the center.

It is a violation of your insurance contract to not pay co-payments and deductibles. It is also **unlawful to routinely waive or fail to collect or discount co-payments, deductibles, coinsurance or other patient responsibility payments** per the Federal False Claims Act, Federal Anti-Kickback Statute, and State and Federal insurance fraud laws. Meridian Health Services staff are not allowed to waive or apply a discount to fees deemed the patient's responsibility except as outlined in the centers Charity Care or Financial Policy.

I consent to MERIDIAN HEALTH SERVICES to provide my third party payer(s) the information necessary to complete billing for the services I receive. I understand billing may be processed electronically. I consent to payment to MERIDIAN HEALTH SERVICES for any third party benefits to which I am entitled. I understand all claims will be submitted at the Center's full charges. In the event benefits are paid directly to me, I agree to provide these payments to MERIDIAN HEALTH SERVICES. I AUTHORIZE information to be given to my Primary Care Physician if my insurance company so requires it, including Substance abuse information.

I understand I have the right to revoke at any time the consent to bill third party payers and/or consent of payment to MERIDIAN HEALTH SERVICES for any third party benefits. I also understand that MERIDIAN HEALTH SERVICES may disclose information to another health care provider or health plan so that the other provider or plan can obtain payment for services (e.g., disclosures may be made to a laboratory or the hospital for their billing purposes.).

I understand this agreement will remain in effect until all payments have been received and my case is closed.

_____

Responsible Party/Guardian/Financial Agent — Date Signed

_____

Witness — Effective Date

_____

Consent Revoked (signature) — Date Revoked