Hunt Regional Medical Partners

FINANCIAL POLICY AND DISCLOSURE

Hunt Regional Medical Partners strives to collect the appropriate co-insurances due at the time of your visit or prior to your procedure.

In some cases, it is not possible to determine the exact amount of financial liability the patient will have at the time services are rendered.

Hunt Regional Medical Partners has a formula we use to estimate the amount we expect the patient will be responsible for according to the insurance benefits. Benefits are verified routinely.

Please be advised that the amount we collect at any given time may be an estimate based on the information available at the time the insurance benefits were verified.

It is possible that your insurance company will deem a different amount due by you than what was initially collected, for services rendered by our office.

If we receive an explanation of benefits from your insurance company that reflects a higher amount due from you, we will be obligated to collect the remaining amount. This additional amount may be collected through a billing statement or when you present to the office for a subsequent visit or service.

We may not reduce, waive, or otherwise forgive additional amounts due. Our managed care contracts stipulate that it is our responsibility to collect the amounts due as deemed by your insurance plan coverage.

If we estimate and collect more than what your insurance deems due, we will refund the overpayment to you.

If you have any questions about this statement, please direct them to the front office or clinical staff. We value you as a patient and thank you for choosing Hunt Regional Medical Partners to assist with your healthcare needs.

PATIENT ASSIGNMENT OF BENEFITS

I hereby authorize and instruct my insurance carrier to make a payment directly to **HUNT REGIONAL MEDICAL PARTNERS** benefits otherwise payable to me. I agree to personally pay for any physician charges that are not covered by or collected from any applicable insurance program, including any deductibles, coinsurance or copayment amounts. This is a direct assignment of my rights and benefits under this policy. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in this case. I authorize Hunt Regional Medical Partners to initiate a complaint to the Insurance Commissioner if necessary for any reason on my behalf.

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Patient/Guardian Signature Date