FINANCIAL POLICY

Pt. Name: _____
DOB: _____
MRN: _____

Thank you for choosing Sansum Clinic as your healthcare provider. We are committed to providing an excellent health care experience. Please read and sign our financial policy prior to your treatment. [Sansum Clinic accepts cash, checks and all major credit cards. We assess a $25 service charge for each returned check.]

Appointment Cancellation and No-Shows: I understand it is my responsibility to cancel any appointments at least 24 hours prior to the scheduled appointment. If I fail to provide at least 24-hour notice of cancellation or if I fail to appear for a scheduled appointment, I understand that I will be charged an appointment cancellation fee. I agree to pay the appointment cancellation fee upon receipt of my statement.

Uninsured Patients: A deposit is required at the time of service. The deposit will not be waived. The deposit may not cover all services rendered and I agree to pay the remaining balance for services rendered. I will be responsible for payment upon receipt of my statement. **HMO Patients:** Any co-pay must be paid at the time of service. My co-pay is an amount determined by my insurance policy and benefit package. I agree to pay all services that are not covered by my health plan; I will be responsible for payment upon receipt of my statement. **PPO and Private Insurance:** With a copy of my insurance card and assignment of benefits on file, Sansum Clinic will bill my health plan and extend the appropriate contractual reduction on behalf of my insurance plan. I agree to pay all services that are not covered by my health plan; I will be responsible for payment upon receipt of my statement.

Medicare Patients: Sansum Clinic is a Medicare Part B participating provider. I will be responsible for the Medicare deductible as well as 20% co insurance of the Medicare allowable. Deductibles and the co insurance will not be waived. I will be responsible for non covered services under the Medicare program. I will be responsible for payment upon receipt of my statement.

Non-Assigned/Non-Participating Insurances: Sansum Clinic is not contracted or participating with my current health plan. I am choosing to obtain services that will be considered out of network by my health insurance. I agree to pay a deposit for each visit and understand the deposit may not cover all services rendered. I understand Sansum Clinic will not negotiate reduced fees with my health plan and I will be responsible for all services rendered. I will be responsible for payment upon receipt of my statement. It is recommended that you contact your insurance company to determine coverage, benefit, and prior authorization requirements

Accidents & Motor Vehicle Injuries: Sansum Clinic providers have the discretion to decide whether or not to see patients injured in motor vehicle accidents or for other liability injuries. Sansum Clinic does not have to agree to accept liens. In all cases, I am responsible for the costs of my care and agree to pay for all services rendered upon receipt of my statement.

Billing Information: I will provide complete & accurate information & notify Sansum Clinic of changes to any of my information (address, phone number, insurance). Sansum Clinic will use reasonable efforts to submit claims to my insurance & promptly provide me with a statement. If for any reason, amounts that I am responsible for are not paid promptly, including if my statement is returned as undeliverable, I may be referred to a collection agency (Financial Credit Network). I also understand

that Financial Credit Network or any company acting on their behalf, may use various dialing and communications methods to reach me at the telephone number(s) I have provided. This includes, but is not limited to dialing or texting my wireless telephone number, which could result in charges by my wireless carrier, either manually or through the use of automatic dialing technology and/or prerecorded messages.
I am the guarantor for the minor patient and by signing this form I acknowledge financial responsibility for any and all copay's, deductibles, co-insurance and non covered services. I am aware any court ordered judgments must be determined between the individuals involved without involvement of Sansum Clinic. I will be responsible for payment upon receipt of my statement.

ASSIGNMENT OF INSURANCE BENEFITS: *I understand that Sansum Clinic will maintain records of services it renders to me and in general will not release information without my specific written consent. I am aware that Sansum Clinic may release information concerning my treatment and the services it renders to me if doing so is necessary for public and private health insurance plan reimbursement. I authorize Sansum Clinic to release any medical, psychiatric, and substance dependency information necessary for processing claims. I permit a copy of this authorization to be used in place of the original. I request that payment under my medical insurance be made directly to Sansum Clinic. I understand I am responsible for charges not paid by my insurance carrier, unless the carrier and Sansum Clinic have agreed otherwise.*

I HAVE READ THE FINANCIAL POLICY ABOVE. I UNDERSTAND IT AND AGREE TO IT.

Full Name (Please Print):	**Relationship to Patient:**
Signature:	**Date:**

Sansum Clinic does not and shall not discriminate on the basis of race, color, national origin, ancestry, age, sex, sexual orientation, marital status, religion, disability or any other characteristic protected by law. See more at SansumClinic.org.