SLMC Accont # _____

Financial Policy & Consent for Medical Treatment

Patient Name: _____DOB_____

Consent for Treatment

- I consent and authorize the physician(s) who may attend me, their assistants, including those employed by St. Louis Medical Clinic (SLMC) to provide medical care, tests, procedures, services and supplies considered advisable by my provider. In consenting to treatment, I have not relied on any statements as to results.

Account Responsibility

As the patient, or the patient's representative, registered with St. Louis Medical Clinic (SLMC), you are agreeing to accept responsibility for all balances incurred on behalf of the named patient's medical care. Patient balances are due within 14 days of receipt of a statement. If you feel your statement is incorrect, have a concern regarding insurance, or are experiencing financial difficulties, please contact our billing department as soon as possible by calling (314) 432-1111.

The individual (patient or representative) signing this Financial Policy will be responsible for any charges associated with the patient's account.

Co-Pays & Payment at the Time-of-Service

If required by your insurance plan, you will be expected to pay your co-pay each time the patient is seen in our office. SLMC accepts cash, checks, and all major credit cards.

In addition, payment will be expected at the time of service when:

- SLMC is not contracted with the patient's insurance plan
- SLMC is not able to verify insurance eligibility
- The patient does not have insurance coverage
- The patient has new insurance coverage, but is unable to provide an insurance card

Professional Services Rendered & Fees

- If the patient is seen for a scheduled preventive visit and another condition is treated at the same time, the provider will bill for each service performed in accordance with CPT coding/billing guidelines
- A $35.00 fee will be charged for any checks that are returned by the bank
- Patients are responsible for notifying SLMC when scheduling an appointment and at check-in if they are presenting for evaluation and management of a Worker's Compensation claim. Not all providers will render and/or third-party bill at the time of service and for filing any claims for reimbursement on their own behalf
- SLMC will not file automobile accident claims. Patients will be responsible for paying any associated charges at the time of service and for filing any claims for reimbursement on their own behalf

SAINT LOUIS MEDICAL CLINIC

SLMC Accont # _____

Cancellation/No Show Policy

- SLMC understands there may be times when you miss an appointment due to emergencies or obligations to work or family. If you need to cancel or reschedule, please provide 24-hours' notice
- SLMC reserves the right to charge an appointment no-show or late or late cancellation fee of $35.00
- SLMC reserves the right to discharge a patient for consistent cancellations and/or no-show appointments
- SLMC will notify you in writing, via certified mail, if you are discharged from care

Assignment of Insurance Benefits

- Inconsideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by SLMC, all physicians and providers, I authorize direct payment to SLMC of all insurance benefits applicable to these medical and other services, which are now or which shall become due and payable to me. In addition, I hereby authorize payment to SLMC of applicable insurance benefits for medical and/or surgical services rendered by physicians for who SLMC is authorized to bill and collect
- I certify that the information given to me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare/Medicaid Program or its Intermediaries or carriers concerning this or a related claim filed by SLMC. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for the deductibles for each year and/or visit, the remaining co-insurance and any other non-covered personal charges
- I acknowledge that I have read and understand the policies stated above and agree to accept financial responsibility for the services rendered to the patient. I understand that SLMC may file a claim, on my behalf, with my insurance company and that any balance not paid by insurance is my responsibility (contractual write offs excepted). I understand that SLMC can only code and file a claim for medical services with a diagnosis that was encountered and documented in the medical record. Altering a diagnosis code in order to secure insurance payment may be inappropriate and possibly fraudulent. SLMC adheres to CPT coding guidelines
- I authorize the release of any medical information necessary to facilitate the processing of insurance claims

Past Due & Collection Accounts

Delinquent account may be placed with an outside collection agency. If placed with an agency, the account will be assessed a 25% collection fee. **Placement of an account with an agency will result in termination of the patient/provider relationship**.

This authorization and consent shall remain in effect for all current and prior services, and shall remain in effect for any future services until or unless revoked by me in writing. My signature below is my acknowledgment that I understood this request for consent and that I understand its contents. This consent may not be altered in any manner.

_____

Signature of Patient or person authorized to consent Date Patient's relationship to person