CALVARY
Medical Clinic

Where Your Healing Begins

Authorizations, Acknowledgements, and Agreements

INSURANCE REQUIREMENTS: I understand that my contract for services provided is between Calvary Medical PA and myself. The Clinic will process insurance claims as a courtesy for our patients and will accept direct payment from the insurance carrier for the portion of the charges that are covered by my plan. I understand that I am responsible for providing the clinic with my insurance carrier information. I understand that I am responsible for all co-pays, any plan deductibles that have not been met, charges above plan allowable charges when clinic is non-participating with the plan, and charges not covered by the terms of my policy. I understand I will be responsible for payment in the event Medicaid or my personal insurance determines requirements set forth by my insurance company were not met, some or all services provided were not deemed medically necessary, or services were non-covered under my plan. Such services may include but are not limited to office visits, preventative medicine examination, pre-employment exams, treatment for an accident, laboratory studies, genetic studies, medications, physical therapy, x-rays, procedures, or emergency room care my insurance company does not deem as emergent or that I failed to obtain either pre- or post-treatment authorization per the terms of my policy. It is your responsibility to provide your insurance company with any additional information they request that may assist in processing your claim. Please be aware that the balance of your claim(s) is your responsibility whether or not your insurance company pays for your claim(s) unless family qualifies for a sliding fee discount. If your insurance changes, please notify us before your next visit so that we can make sure we bill the appropriate insurance and that you receive the maximum benefits offered by your insurance. Please contact your insurance company with any questions that you may have regarding your insurance coverage because knowledge of your insurance benefits and insurance provider network is your responsibility. _____ (initial)

NO INSURANCE OR UNDER INSURED: If you do not have any insurance or limited insurance and you are unable to pay the full amount due for medical care, you may qualify for a sliding fee discounted program offered by our organization. This program is designed to provide free or discounted care to those who have no means, or limited means, to pay for their medical services. If you are insured, uninsured or underinsured, your visit fee may be discounted on a sliding fee scale based on family income and composition according to federal guidelines. Our staff will assist you in determining if you qualify for a discount; if you do, they will also assist you with the application. _____ (initial)

SELF PAYMENT ACCOUNTS: I understand that if I do not have insurance coverage that I am personally responsible for all charges incurred at the time of my appointment. I understand that the clinic cannot determine the cost of services prior to the visit and that some charges may not be available at the time services are rendered. I agree to pay any balance due. It is my responsibility to contact the Revenue Cycle Representative Billing Vendor at myeMED Management, LLC at (877) 769-3633 if I am unable to pay my account in full for any charges billed to me. The Clinic will provide information, upon request, regarding available community healthcare resources that may be available to patients who qualify based on financial need. _____(initial)

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize Calvary Medical PA, LabCorp, Quest Diagnostics, and/or other reference labs who performed diagnostic testing to release any medical information or statement of charges associated with the services provided to the following: other healthcare providers who provide services to me, any organization or healthcare provider requiring the medical information for payment of claims associated with the services I receive, any person or entity who has agreed to be Responsible Party for payment of the services I receive or for any purpose needed for healthcare operations. _____(initial)

DIRECT PAYMENT OF INSURANCE BENEFITS INCLUDING MEDICARE AND MEDICAID: I request payment of authorized benefits for services furnished by or in Calvary Medical PA to be made on my behalf directly to Calvary Medical PA. _____(initial)

MEDICARE DRUG AND IMMUNIZATION DENIAL: I have been informed outpatient Medicare coverage does not include drugs, biologicals determined by Medicare to be self-administrable or vaccinations. I understand if I am a Medicare recipient, I will be responsible for payment. _____(initial)

MEDICARE, MEDIGAP AND MEDICAID BENEFITS: I request that payment of authorized Medicare, Medigap, and/or Medicaid benefits, be made on my behalf to Calvary Medical PA for any services furnished to me by providers employed by Calvary Medical PA to the extent permitted by law. I authorize Calvary Medical PA, LabCorp, Quest Diagnostics, and/or other reference labs to release to Medicare and/or Medicaid, to the Social Security Administration and/or it intermediaries or carriers, and to any peer review organizations, any information needed for this or a related Medicare and/or Medicaid claim. _____(initial)

AGREEMENT TO PAY FOR SERVICES: I agree, whether I sign this as an agent or as the patient, that in consideration of services to be rendered to me, I hereby individually obligate myself to pay the charges by Calvary Medical PA in accordance with its regular rates and

terms. However, I am aware that any patient arriving at the facility will have a medical screening examination performed regardless of the ability to pay. _____(initial)

ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES: Beginning April 14, 2003, Federal law requires that healthcare providers give you a copy of their Notice of Privacy Practices the first time you present for services, and subsequently, anytime a change is made in the wording of their notice. The notice explains how the healthcare provider maintains the privacy of your health information. _____(initial)

CONSENT TO TREATMENT: I consent to examination and/or treatment provided by Calvary Medical PA under the instructions of a Physician, Advanced Nurse Practitioner, or Physician's Assistant. This may include radiologic examination, laboratory procedures, anesthesia, medical and surgical treatment, or other services provided by the clinic. I understand that additional consents may be required for specific procedures and/or treatments. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments or examination by the providers/clinic. This consent has been fully explained to me, and I understand its conditions. _____(initial)

TELEPHONE CALLS: Calvary Medical PA staff/providers do not take/return calls while seeing patients. Your call will be returned either at lunch or after seeing patients for the day. If your call is due to a medical emergency, the front office staff can take the call and notify provider to get direct instructions from them. In case of emergency after hours you should contact the clinic to reach the after-hours answering service to be connected with the provider on-call or go the emergency room of your choice. _____(initial)

APPOINTMENT NO SHOWS/CANCELLATIONS: Calvary Medical Clinic understands that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel your appointment within 24 hours, you may be preventing another patient from getting an appointment when needed. Conversely, a situation may arise where a patient fails to cancel an appointment and we are unable to get you in for an appointment. We are therefore implementing No Show Policy. A $25 fee may be charged to all patients failing to cancel their appointment within 24 hours or if the appointment is missed without notice. This fee is not covered by your insurance company. You may be required to pay the $25 fee along with your co-payment, coinsurance or deductible at the time of visit of your next appointment. For those patients that continuously fail to keep their scheduled appointment, fail to cancel their appointment within 24 hours or fail to notify our office may be discharged from the practice. _____(initial)

In the event that an individual is suspected to be exposed to my blood or body fluid, I consent to be tested to determine whether or not my blood contains contagious viruses, including Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus. I understand there will be no charge to me for such laboratory testing done as a result of exposure. _____(initial)

MID-LEVEL PRACTITIONERS: Calvary Medical PA employs mid-level providers also known as Advanced Nurse Practitioners or Physician Assistants. These providers are licensed by the State of Texas to provide care under the supervision of licensed physicians. Some insurance plans will not reimburse for their services and/or they may pay only for a percentage of the services. It is the patient's responsibility to determine your coverage prior to treatment. Patients who are treated by Mid-Level providers are responsible for the charges regardless of the coverage provided by their insurance carriers. _____(initial)

PRESCRIPTIONS: All prescriptions are filled electronically. As a result, information about ALL medications you are taking will be shared by SureScripts and RXHub (Vendors who transmit prescriptions) with the Clinic and any other healthcare provider or medical institution that is treating you. ***There is not an option to opt out of this process***. _____(initial)

PATIENT PORTAL: The patient portal is a secure web site that allows you as a patient age 18 and older to access your Personal Health Record (PHR)) including medications, lab results, and medical history via the internet. . By using the patient portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to notify us should your password be stolen. You agree to not hold Calvary Medical PA responsible for any network infractions beyond our control. _____(initial)

COMMUNICATIONS: The clinic adheres to all Federal State, and Local regulations concerning sharing of personal health information. Regulations allow for sharing of personal health information between healthcare providers/healthcare facilities that treat you. You may authorize others to obtain this information on your behalf. _____(initial)

THE UNDERSIGNED CERTIFIES HE/SHE HAS READ THE FORGOING, AND IS THE PATIENT OR THE DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT, AND AGREES TO THESE TO THESE TERMS UNLESS SPECIFIED IN WRITING ABOVE. *THIS AUTHORIZATION IS VALID UNTIL REVOKED IN WRITING*.

Patient Signature: _____ Date: _____

Patient Representative Signature: _____

Reason for Representative Signature: ☐Child ☐Guardian ☐Power of Attorney ☐Other (specify) _____
Note: Non-custodial parents, guardians, or those with Health Care Power of Attorney must have a copy of the supporting documents on file with this office.