

FINANCIAL POLICY

Medicare Part B

All physicians/providers at Apex Florida, LLC are participating Medicare Part B providers. He/She will accept assignment on all Medicare Part B claims. By accepting assignment, he/she agrees to adjust your charges reflect the Medicare approved amount. However, Medicare only pays 80% of the approved amount, and the remaining 20% is your responsibility. If you have supplemental insurance, we will bill supplement insurance for the 20 %balance. **If there is any reining balance after Medicare and supplement insurance payment, it is the patient's responsibility.**

Private Health Insurance

As a courtesy to you, we will file claims with your insurance company. Please understand, however, that your insurance reflects a contract between you and the insurance company, not with any provider at Apex Florida, LLC you, as the patient, are ultimately responsible for your bill. **Patient without health insurance will be expected to pay at the time of service or to make payment arrangements with management or the billing office. We may also collect at the time of service, any fee that will be paid directly to you from your insurance company, as well as any co-pay or deductible amounts.**

Managed Care Networks

All providers at Apex Florida, LLC are participating providers with BCBS/FL and community Health Partners. We will file claims to insurers contracted with these organizations. Co-pay, co-insurance and/or deductibles will be due at the time of service. All Providers also participates with a number of other managed care organizations. If you have any questions regarding participation, please as ask the front desk.

Usual, Reasonable and Customary

Some insurance carriers have established "usual" and "reasonable and customary" maximum amounts that they will pay for specific procedures. These amounts may vary with each insurance company. Any amount considered in excess of the "usual" and "reasonable and customary" amount that is not paid by the insurance company, becomes the patient't responsibility. In the event we have a **"returned check", the patient will be assessed a \$35.00 "returned check fee" payable to Apex Florida, LLC.** The check will be returned to the bank. Cash payment will be due from the patient at the time of service for both the returned check amount and the "returned check fee"

Non- Covered Services

Not all services are covered by all insurance health plans. Some services may not be covered by your specific or individual policy. **Services not covered or considered payable by the insurance company becomes the patient's responsibility.**

Signature of Patient/ Guarantor

Date

APEX FLORIDA, LLC

Consent for Purpose of treatment, payment or Health Care Operations

I consent to the use or disclosure of my protected health information by Apex Florida, LLC, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Apex Florida, LLC.

I understand that diagnosis or treatment of my by Apex Florida, LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations, Apex Florida, LLC is not required to agree to the restrictions that I may request. However, if Apex Florida, LLC agrees to a restriction that I requested, the reliance on this consent.

My" protected health information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Apex Florida, LLC Notice of Privacy practices prior to signing this document.

Apex Florida, LLC Notice of Privacy has been provided to me.

The Notice of Privacy Practice for Apex Florida, LLC describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of health care.

A summary of the Notice of Privacy Practices for Apex Florida, LLC is also posted in waiting room.

This Notice of Privacy Practices also describes my rights and the duties of Apex Florida, LLC with respect to my protected health information.

Apex Florida, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practice.

I may obtain revised Notice of Privacy Practices by contacting Apex Florida, LLC 6333 North Federal Highway suite 250 Fort Lauderdale, FL 33308

Name of patient or Representative (Please print)

Date

Signature of Patient or Representative

Employee Initial

Financial Policy

Updated 01/01/2011

Un-Paid Balance:

The patient or guarantor is responsible for any balance due to Apex Florida, LLC. If the balance is not paid in a timely manner, the account will be referred to a collection agency and assessed an additional fee of \$30. If a collection account is not paid within 14 days, there will be an additional 100% fee attached to the outstanding balance due to attorney fees.

I have read and fully understand this information and I agree to accept financial responsibility for the unpaid balance of all accounts in the event the following authorization is insufficient to liquidate the account.

I request that payment of authorized Medicare benefits be made on my behalf to Apex Florida, LLC for any services furnished me by this provider.

I hereby assign and transfer any insurance benefit due me for the professional services that I have received, to Apex Florida, LLC.

I authorize the release of any medical information necessary to process insurance claims.

Signature of Patient/Guarantor

Date