HARMONY HEALTH CLINIC

Financial Policy
Effective November 1, 2022

Patient Name:_______________________________
(Please print clearly)

Thank you for choosing HARMONY HEALTH CLINIC as your healthcare provider. **Please carefully read and initialize each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1.__________I understand that if I **do not have my insurance card,** referral, and / or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2.__________ I understand that HARMONY HEALTH CLINIC will **collect all co-payments at the time of visit** and any deductibles and possible coinsurance amounts provided during insurance verification at the time of service. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and HARMONY HEALTH CLINIC. Any overpayment to your account will be refunded to you **at your request** after payment and/or remittance has been received from your insurance company.

3.__________ I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF MUST BE PAID WITH CASH OR CREDIT CARD and I will no longer be able to pay for any services by personal check.

4.__________ I understand that if I am unable to make a SCHEDULED APPOINTMENT OR PROCEDURE, I need to contact HARMONY HEALTH CLINIC **at least 24 hours before my scheduled appointment time.** Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and may keep others in need of medical care from being seen. **A $25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS**.

5.__________ I understand that if my account **is not paid in full within 90 days of a statement date,** a 35% collection agency processing fee may be added to the outstanding balance and may be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

6.__________ HARMONY HEALTH CLINIC will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process **a** claim for services. It is also my responsibility to notify HARMONY HEALTH CLINIC if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS. **I UNDERSTAND IT IS MY RESPONSIBILITY TO PROVIDE A CURRENT INSURANCE CARD TO BE SCANNED TO MY RECORD**.

7.__________ HARMONY HEALTH CLINIC may charge a fee to the patient for any additional forms including but not limited to FMLA paperwork.

I HAVE READ AND AGREE TO ALL THE PROVISIONS OF THE ABOVE FINANCIAL POLICY. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL PROFESSIONAL FEES INCURRED FOR PROFESSIONAL SERVICES PERFORMED BY THE PROVIDER.

Signature of Responsible Party:______________________________________ **Date:**__________________

ASSIGNMENT OF BENEFITS

We require *insured patients to complete assignment* of benefits *authorizing* insurance *to remit payment to the physician's* office. I hereby assign all medical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to HARMONY HEALTH CLINIC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not paid or adjusted by provided insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party:________________________________ **Date:**____________________

Patient Acknowledgement of the Notice of Privacy Practices and Consent for use and disclosure of personal health information (Enclosed)

Print Patients Name____ Date______________________

I, ____, acknowledge that I have either received a copy of this office's
(Signature of Patient or Parent or Legal Guardian)

Notice of Privacy Practices or that this office's Notice of Privacy Practices was made available to me to receive. I also consent to disclosure of my personal health information by your office for treatment, billing, payment, and health care operations as outlined in the Notice of Privacy Practices.

ACKNOWLEDGEMENT:

The Above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in the clinic's Notice of Privacy Practices. I authorize my insurance benefits to be paid directly to HARMONY HEALTH CLINIC as indicated on the claim. I understand that I am responsible for all fees and balances, regardless of insurance coverage.

____ ____________________________________

Patient/Guardian Signature ***Date***

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Patient's Name:____ **Social Security#**:________________________
First Middle Last

Date of Birth:______________ **Address**: ____

City:_________________ **State**:_________ **Zip Code**:_____________

Email Address:________________________________ **Portal Sign Up**? ❒ Yes ❒ No **Sex**: ❒Male ❒ Female

Primary Phone #:____________________________ **Alt Phone #**:_____________________________________

Employer Name:______________________________ **Employer Phone#**:_____________________________

Check all that apply:

Race:	Marital Status:	Ethic Group:	Language:	Employment Status:
❒Decline	❒Single	❒Non-Hispanic	❒English	❒Employed
❒White	❒Married	❒Hispanic/Lation	❒Spanish	❒Retired
❒American Indian/ Alaska Nat.	❒Divorced	❒Decline		❒Student
❒Asian	❒Seperated			❒Not-Employed
❒Black/ African American	❒Widow			
❒Nat. Hawaii/ Other Pac Islander				
❒Other:_____________				

Reason for visit:____

Emergency Contact: if under 18, please list all legal guardians:

Name:______________________________ Phone#:____________________________ Relationship to patient:________________________

Name:______________________________ Phone#:____________________________ Relationship to patient:________________________

Name:______________________________ Phone#:____________________________ Relationship to patient:________________________

Insurance Information:

Primary Insurance:____ Plan Name:_____________________________________

Policy #:_________________________ Group #:____________________________ Group Name:___________________________

Claims Address____Phone #:_____________________________

Policy Holder's Name:____ Date of Birth___________________________

Soical Security Number:_______________________________________Relationship to the patient:_____________________________

Secondary Insurance:____ Plan Name:_____________________________________

Policy #:_________________________ Group #:____________________________ Group Name:___________________________

Claims Address____Phone #:_____________________________

Policy Holder's Name:____ Date of Birth___________________________

Soical Security Number:_______________________________________Relationship to the patient:_____________________________

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Patient Name:____ **Date of Birth**_____________

Authorization to release non-public personal information:

I certify that I have received and read a copy of the Harmony Health Clinic Patient Information Policy. I hereby authorize Harmony Health Clinic to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

Authorization to mail, call or email:

I certify that I understand the privacy risk of the mail, phone calls, and email. I hereby authorize Harmony Health Clinic representative or my physician/ provider to mail, call or email me with communications regarding the patients health care including but not limited to such things as appointment reminders, referral arrangements and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Harmony Health Clinic to that effect in writing.

Consent to treatment:

I hereby consent to evaluation, testing, and treatment as directed by Harmony Health Clinic or his or her designee as the patient and or parent guardian. Please list all persons/HIPAA contacts who may have access to the patient's medical information. Example: To be able to bring a child to appointments and authorize lab work/ immunizations/ testing, ect, prescription pick up, general medical information, lab results and medical emergencies.

If their name is NOT on the list, they will not be allowed to have any information on the patient. Please make sure to update any changes at each appointment.

Our office will ask to make a copy of their photo I.D. when bringing your child into the office.

Name	Phone Number	Relationship to Patient *if patient is under 18 Please include the Date of Birth*

Patient (age 18 or older)/ Guardian Name:________________________________ Date:____________

Please Print

Patient (age 18 or older)/ Guardian Signature:________________________________ Date:____________

Harmony Health Clinic

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization : In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.