B.I.S. Community Clinic
Serving Bedias, Iola, Singleton and Surrounding Communities

AUTHORIZATION AND CONSENT FOR MEDICALTREATMENT, AND PAYMENT GUARANTEE

Thank you for choosing B.I.S. Community Clinic. This policy is executed to assure the financial resources necessary to maintain this health care practice. It is our mission to partner with individuals, families, and employers to provide personalized, affordable, and accessible high-quality wellness and preventive health services for all. Thus, we strive to advance patient health outcomes of our community as a leading stable, self-supported Nurse Practitioner managed Rural Health Clinic through effective planning, advocacy, coordination, collaboration, evidenced-based practice, and education. Please read and sign where indicated – this document describes your financial responsibilities. This is a legally binding agreement between B.I.S. Community Clinic and you. The words, I, me, my, you and your all refer to the patient.

GENERAL CONSENT FOR MEDICAL TREATMENT: As a patient of B.I. S. Community Clinic, I understand that the clinic has an obligation to provide appropriate care and treatment of all patients. I hereby authorize the clinic, and its providers to order and/or provide direct and indirect services in efforts to diagnose and treat diseases, disorders, injuries or other conditions. I understand that the providers will act in good faith to provide quality care and treatment. However, a specific cure or resolution cannot be promised or guaranteed. My patient rights include my participation in my care plans and treatment options. I may revoke this consent for general treatment at any time. Additional informed consent shall be given for medical procedures or treatments for which I need to specifically consent.

ASSIGNMENT OF BENEFITS I hereby authorize B.I.S. Community Clinic to bill my insurance company or other designated third-party payer for the services provided as related to my care. I acknowledge that the clinic will file claims on my behalf as a courtesy and that I, as guarantor of the account, remain responsible for payment of services. I acknowledge I am responsible for showing my insurance card at every visit and providing accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I acknowledge that I am also responsible for deductibles, co-insurance amounts, co-payment amounts, and non-covered services. I/we agree to pay the established rates of the clinic for all services rendered for the patient named below. I also acknowledge that I am aware that the clinic may have policies for financial counseling and assistance. This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document. I authorize the release of any medical information necessary in order to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured, the clinic may offer a self-pay cash discount for new and established patients if available, and I am responsible for the charges of all services provided to me at the time of service.

PATIENT FINANCIAL RESPONSIBILITY: Payments accepted are cash, check, and credit card. I understand there will be a $25.00 fee for all returned checks, I understand if I no show or cancel my appointment with less than 24 hours' notice, I personally may be charged a $25.00 fee in accordance with clinic policy. I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give B.I.S. Community Clinic my current address and other contact information.

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PATIENT FINANCIAL RESPONSIBILITY Cont':
I understand that if I fail to pay the balance on my account this may result in B.I.S. Community Clinic pursuing any collection means possible. Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that B.I.S. Community Clinic has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to, to the extent allowed by law: (i) late fees and charges and interest due as a result of such delinquency; (ii) all court costs and attorney's fees; and (iii) collection agency fees. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history. If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

MEDICAID ELIGIBILITY: If you are a Medicaid patient, you should present a valid eligibility card at the time of registration and prior to the time of service. Your eligibility status will be verified monthly. Without verification of coverage, you will be responsible for the full/entire balance of your account. If BIS Community Clinic is not the Primary Care facility listed, a referral is required from your PCP prior to service being provided. As a courtesy to you, your account will be billed to Medicaid when we receive all necessary information. If at any time you are not eligible for Medicaid coverage and wish to be seen, you will be treated as a self-pay patient and must make payment at the time of service.

DIVORCE: Unless provided acceptable documentation showing otherwise, in case of divorce, or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

I UNDERSTAND THAT MY SIGNATURE REQUESTS PAYMENT BE MADE TO PAY MY CLAIM. MY SIGNATURE ALSO AUTHORIZES THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY MY CLAIM. MY SIGNATURE ALSO AUTHORIZES THE RELEASE OF BENEFITS PAYABLE AND MEDICAL INFORMATION NECESSARY TO PAY ANY SECONDARY INSURANCE PAYER. THE UNDERSIGNED CERTIFIES HE/SHE HAS READ AND UNDERSTANDS THE ABOVE INFORMATION AND AUTHORZATION. IT ALSO CERTIFIES YOU HAVE RECEIVED OUR NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS. THIS AUTHORIZATION/ACKNOWLEDGEMENT REMAINS IN FORCE UNTIL SUCH DATE THAT IT IS REVOKED OR REPLACED.

Patient Name:_____ DOB_____

Parent/Guardian/Signature_____Date_____