FINANCIAL RESPONSIBILITY, ACCEPTING INSURANCE, RELEASES AND CONSENTS *(ver.8.0)*

Health problems occur and deserve treatment every day, and **ExpressHEALTH Clinic Corporation** ('**EHC**', '**we**' or '**us**') provides Convenient Care services seven days a week, charging only modest fees. **We** expect payment in full at the time of service **unless we** accept assignment of **your** insurance benefits ('Accept Assignment').

- ✓ **We contractually participate with many of the major insurance plans in this area** and those plans or insurance companies are identified on **our** signage. **However, we do not Accept Assignment of all insurance plans**. Before service is rendered, **you** should confirm with **our** staff (i) **our** policy regarding **your** insurance plan(s) and (ii) **your** Financial Responsibility.
- ✓ If we Accept Assignment, **you** must provide **us** with the correct insurance information and valid proof of identity. Payment in full constitutes **our** receipt of **your** insurance benefits plus payment of **your** Financial Responsibility under **your** plan. **We** also want **you** to know that:
  - Most insurance plans do not pay the full amount and, if **we** Accept Assignment, **you** are responsible for the balance pursuant to **your** plan (**your** 'Financial Responsibility', such as requirements for co-pay, coinsurance, deductible and non-covered charges).
  - At the time of service, **we** expect **you** to pay **us** the amount **we** estimate (using **our** best efforts) to be **your** Financial Responsibility. After filing for **your** benefits, if **we** learn from **your** insurance plan that **your** responsibility is different from the amount **you** paid **us**, **we** will either bill **you** for any deficiency or refund **you** the amount of any overpayment.
  - Many insurance plans now require **your** Financially Responsibility to be an increased portion of the cost of all health care services, including Convenient Care. For example, if **your** plan requires increased co-pays for Specialty, Urgent or Convenient Care services, **your** Financial Responsibility will be impacted.
- ✓ If **we do not participate in your plan's network and do not Accept Assignment of your insurance plan:**
  - **We** must receive payment in full by **you** at the time of service. However,
  - **We** will provide **you** with information that will help **you** file for reimbursement by **your** insurance plan,
  - **We** reserve the right to modify these requirements based on **our** experience with **your** insurance plan, and
  - **We** suggest **you** contact **your** plan and ask them to arrange for **us** to participate in their network by calling **us** at (865) 475-9969 ext.101.
- ✓ **Special Requirements Regarding Original Medicare and Medicare Advantage participants:**
  - **Original Medicare Part B** covers eligible health care provider services provided by us. You are responsible for an annual deductible and a co-pay of 20% of the cost of covered services. You may have a Medicare Part B Supplement plan or other secondary insurance coverage that will pay your deductible and co-pay.
  - **Medicare Advantage (MA) plans** (i.e., **PPO, PFFS, MSA or HMO**) are alternatives to Original Medicare; we accept all **Medicare Advantage** Preferred Provider Organization ('**PPO**') plans that provide out of network benefits, but if you have a Medicare Advantage plan designated as a **PFFS**, **MSA** or **HMO** plan, you should ask our staff if we accept your plan prior to services being rendered.

Patient Name (Please print full name):_____

To ExpressHEALTH Clinic Corporation ("EHC"):

I. Consent for Treatment. I understand that **EHC** Family Nurse Practitioners (FNPs) only test for and treat a limited number of common family illnesses and conditions. I also understand that **EHC** FNPs do not follow up with patients after visit discharge and have no means to access patient's previous health records. It is my obligation to disclose all of the patient health related medical history, current medications and allergies to the **EHC** FNP. I have accurately completed the questions and information on the reverse side of this form. If I have questions regarding any other health condition except for the reason for today's visit with EHC, I will present them to my (or the patient's) regular health care provider and I understand that I will need to follow up with my (or the patient's) regular health care provider. I hereby consent to the test(s), assessment(s) and/or treatment(s) to be performed as recommended by the **EHC** health care provider.

II. Release of Medical Records and EHC Privacy Practices. I hereby authorize the release of medical information about the person named above to (1) all insurance companies and their intermediaries as needed for the claim reimbursement to **EHC**, and (2) to other health care providers who may participate in the treatment of that person. **EHC** has provided me a copy of its privacy practices that I have read (or have had explained to me), understand and approve those practices.

III. Insurance Benefits. I have read and understand **EHC**'s Policies for Financial Responsibility and Accepting Assignment of Insurance, and I desire that **EHC** accept assignment of available related insurance benefits as described in those Policies. I hereby assign to **EHC** the rights for payment of benefits under health insurance policies/plans for services rendered and EHC Accepted Assignment. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original.

Acknowledgment of Responsible Party. I am the Responsible Party with regard to the Patient and have the right, duty and authority to execute this document and be bound by its terms as the Patient, the Patient's Parent/Legal Guardian, or otherwise as the Patient's Responsible Party. The Financial Responsibility for any payments that may be owed to **EHC** is my responsibility.

By signing below, I confirm that I have read (or have had explained to me), understand and agree to the statements herein:

Signed By:_____ Date:_____

Check One: ☐ I am the Patient ☐ Patient's Parent/Legal Guardian ☐ Patient's Responsible Party

If patient is unaccompanied minor, at least 16 or 17 years of age:

Verbal Consent given by:_____ _____ **Date:**_____ **PCC:**_____

Parent / Legal Guardian *Relationship to Patient*