BAY AREA INFECTIOUS DISEASE ASSOCIATES

Thank you for choosing Jose Prieto MD, PA (d/b/a Bay Area Infectious Disease Associates) for your care. We are honored by your choice and trust in our practice. We are committed to providing you with the highest quality healthcare. We ask that you read and sign the acknowledgement form as your understanding of our **Patient Financial And Responsibility Policy** detailed in this form.

A hard copy of this policy shall be provided to each patient on an annual basis and/or when the policy is updated. An additional form shall be signed as understanding of the policy and be completed on an annual basis or when the policy is updated.

Insured Patients

Jose Prieto MD, PA (d/b/a Bay Area Infectious Disease Associates) will bill all plans that we are currently contracted with. **Payment is due at time of service (physician and/or infusion center services) for any patient responsibility (copayment, deductible, and/or co-insurance) based on the quote of benefits received from your insurance carrier prior to your visit**. Patient is responsible for providing a current copy of their insurance card(s) and photo ID during check-in.

If your insurance carrier requires an insurance referral or referral authorization, it is the patient's responsibility to ensure that the referral authorization is received by our office prior to services being rendered. If we do not have a referral authorization on file 24 hours prior to your appointment, your appointment may be rescheduled.

It is the patient's responsibility to notify our office of any changes to insurance coverage, to include but not limited to change or addition of an insurance carrier, primary care physician, or termination of coverage.

Some services that you may receive are considered non-covered, or not considered medically necessary, by your insurance. These services will be your financial responsibility and will be billed to you.

We will submit insurance claims to insurances you have informed our office about. We will assist in every reasonable way we can to get your claims paid. However, there may be times when your insurance company requires information directly from you. It is your responsibility to provide this information if/or when it is requested. If your claim is denied because you failed to provide this information, the balance will become your financial responsibility.

If our office is not contracted with your insurance carrier, you may elect to continue care with our office as a self-pay patient and you will be responsible for payment in full at time of service.

Uninsured/Self Pay Patients

If you are uninsured or elect to be a self-pay patient, payment will be required in full at the time of service.

Assignment of Benefits

I agree with the Financial Policies and request that payment of Medicare & Medicaid and/or any other authorized insurance benefits be made on my behalf directly to Jose Prieto MD, PA (d/b/a Bay Area Infectious Disease Associates) for any services provided to me.

Release of Information
I authorize Jose Prieto MD, PA (d/b/a Bay Area Infectious Disease) to release any medical information about me to the Centers for Medicare & Medicaid Services or any other insurance company that is needed to determine these benefits or the benefits payable for related items and services.

Outstanding Balance, Returned Check Fee, and Collection Procedures
After your claims are processed by your insurance carrier(s) (if applicable) and the EOB (explanation of benefits) is received by our office that reflects patient responsibility, we will mail two (2) statements to the address on file.

Please be aware that if your balance remains unpaid after the 2 billing statement cycles, your account may be referred to an outside collection agency. If referred, the outstanding balance must be paid in full or a commitment to pay the outstanding balance with a secured payment method must be on file before another appointment will be scheduled.

A $25 fee will be charged for returned check payment and all future payments must be made using cash, money order, debit card, or credit card.

If you are experiencing a financial hardship and require a payment plan, please contact our billing department immediately to discuss options. Please be aware that that the patient-provider relationship may end, and the patient may be required to seek an alternative medical provider.

Appointment Cancellation, Rescheduling and No-Shows
If you fail to show for your appointment, reschedule and/or cancel within 24 hours of your scheduled appointment date and time, you will be responsible for a $25.00 fee that is required to be paid prior to having another appointment with our office.

Form Completion Fee
There is a fee of $25.00 for completion of forms. Payment is required prior to the release of the forms. Please allow up to 7 business days for completion of forms.

Medical Records Fee
A fee will be incurred for all medical record requests, including patient's personal requests. The fees for patient medical records request are set per Florida Statutes Rule 64B8-10.003 are – the first 25 pages, the cost will be $1.00 per page, for each page more than 25, the cost will be $0.25 per page.

There is no charge for requests from physician practices.

A signed medical release form must be completed prior to forwarding records to providers not directly involved in your care or for patient personal request for records.