Porter Physician Services
Consent for Treatment and Financial Policy

Porter Physicians Services, LLC (PPS) is committed to providing the best medical and surgical care available. It is important to understand that our financial policies are a necessary part of assuring the continuity of our medical office for our patients.

I consent to medical treatment provided by the physician and/or Independent Advanced Practitioner, in accordance with the state laws, scope of practice and licensure of the Medical Staff.

I acknowledge that I received a copy of the Porter Physician Services Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices.

It is the financial policy of Porter Physician Services, LLC to collect payment at the time services are rendered.

- Our physicians participate in many insurance plans and managed health care programs. Our office will submit a claim for services rendered for patients participating in those plans for which our physicians are providers. It is your responsibility to:
- Provide our office with accurate and complete insurance information.
- Bring a photo ID and your insurance card to every office visit.
- Be prepared to pay any co-pay, coinsurance and/or deductible at each visit. Payment can be made by cash, check or credit card, or a payment plan may be developed.
- Make payment, in full, at the time of the visit, for medical care or office procedures that are not covered by your insurance plan.
- Pay any balance due to Porter Physician Services; which may be collected from any PPS locations.
- If you have insurance for which our physicians are not participating providers, or if services provided are part of a worker's compensation or automobile insurance claim, our office will gladly file your claim upon request. Payment for the office visit and any office procedures performed is expected, in full, at the time that services are rendered.
- Patients that do not have insurance are expected to pay for all professional services provided, at the time that services are rendered.
- If you are unable to pay for necessary medical care, you may be eligible for financial assistance. It is your responsibility to inform us of this prior to your office visit.
- It is your responsibility to bring any referrals required by your insurance company prior to your office visit or surgical procedure. If you do not have the required referral, your visit or procedure may be rescheduled, or you may be held financially responsible for all costs of treatment rendered.
- It is your responsibility as the insured to notify us if your insurance carrier requires precertification or authorization.
- If a check is returned for non-sufficient funds, a $20.00 charge will be assessed to the account. This fee along with the amount that caused the NSF must be paid prior to another appointment being scheduled.
- If the patient is a minor (younger than 18 years of age), the patient's parent or guardian is financially responsible for any payments due at the time of service. Non-emergent treatment will be denied for minors not accompanied by a parent or guardian. The parent or guardian is responsible for providing complete and accurate insurance information and for bringing the necessary referrals.
- An account statement will be sent to you, after payment has been received from your insurance company or managed care health plan, indicating any unpaid balance. You are expected to pay any unpaid account balance at that time. In the event that your account becomes more than 90 days delinquent, you agree to pay any unpaid balance including all reasonable costs of collection and reasonable attorney's fees.
- Our physicians and office staff firmly believe that a good patient-physician relationship requires understanding and good communication. Missed appointments will result in a $35 service fee.
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STATEMENT TO PERMIT PAYMENT OF BENEFITS TO PROVIDER

I hereby assign and authorize payment of my insurance benefits, including authorized Medicare benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization directly to Porter Physicians Services, LLC for any services which have been rendered to me. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company. I authorize Porter Physicians Services, LLC to release any medical or any other information for the purpose of processing claims to my insurance carriers, including Health Care Financing Administration and any future insurance changes. This includes information as defined by and for the purposes outlined in the Privacy Notice. I permit a copy of this authorization to be used in place of the original. I have read and understand the financial policies of Porter Physicians Services, LLC. I understand that in the event I do not pay for services rendered and any amounts become delinquent that I shall be obligated for all costs including court and attorney fees made necessary by reason of my failure to pay when due.

I hereby agree and certify that I have read (or have read to me) the above information, understand it, accept the terms and have received a copy of this policy.

_____	_____	_____
Guarantor/Patient Signature	Printed Name	Date
_____	_____	_____
Patient Name	Patient's Date of Birth	Witness