CORNERSTONE
MEDICAL MANAGEMENT, LLC

FINANCIAL POLICY

Thank you for choosing a Cornerstone Physician as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All co-payments and deductibles are due at time of service. Full payment is due a the time of service for all non-covered services. Our contract with your insurance company requires us to collect these from you. With the rising cost of medical care, paying at the time of service is essential in keeping these costs at a minimum. **Payment in full is required without proof of insurance coverage.**

It is your responsibility to check with your insurance company prior to your appointment for verification of benefits such as preventative services, labs, x-ray procedures, etc. Many insurance plans now require you to go to specific labs, x-ray facilities, pharmacies, etc.

It is your responsibility to give us accurate and updated insurance information at each visit. Failure to do so may result in you being responsible for a balance that your insurance company may have otherwise paid. Many managed care insurance plans have strict guidelines regarding timely filing which makes accurate information a necessity. If you are covered under more than one insurance plan, lease remember to give us information on all plans at the time of service.

It is important for you to respond to your insurance company when ANY information is requested from you. Often they will send questionnaires regarding other coverage and will not process your claim until you respond. Some insurance companies require this with your first claim each calendar year. Do no make the mistake of thinking you have already given them this information and it is not necessary to respond. **When your insurance company notifies us they have requested information from you, the balance then becomes your responsibility and remains your responsibility until the claim is paid.**

We understand unforeseen circumstances such as hospitalizations, uncovered services, and unplanned emergencies occur. In these situations when you incur a balance, we require monthly payments with the expectation of paying the balance in full in 3 to 4 months. If this is not possible, please call our billing office at (478) 751-2580.

If monthly payments are not received regularly, your account will automatically move into our collection process. We are willing to work with you on your balance, but communication with our billing office is essential. If you have questions regarding your bill or wish to set up payment arrangements, contact our billing office at (478) 751-2580 or you can e-mail your questions to billing@cstonemed.com.

If you receive a bill that you feel is not your responsibility, it is important for you to call the billing office. Never ignore a bill simply because you feel it is not your obligation or your think your insurance company should pay for it. You cannot assume your insurance company will cover any balance once we have transferred the responsibility of that balance to you. We only transfer responsibility to you after we have had response from your insurance company.
It is important for you to read the explanation of benefits (EOB's) sent to you from your insurance company. This will explain why certain charges are not covered. If you have any question regarding the coverage of your claim, you should contact your insurance company. If you have questions regarding your bill or wish to set up payment arrangements, please contact our billing office at (478) 751-2580.

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Signature of Responsible Party Date

AUTHORIZATION FOR DISCLOSURE OF PHI TO PERSONAL REPRESENTATIVE(S)

I authorize disclosures of my Protected Health Information (PHI) to my personal representative(s) named below:

(Check all that apply) (List Name(s))

_____ Legal Guardian _____

_____ Spouse _____

_____ Parent(s) _____

_____ Adult Friend _____

NOTE: Under federal regulation, the physician may exercise his/her professional judgment to determine the scope and duration of a patient's direction or agreement to disclosures of information to the personal representatives.

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Patient/Guardian Signature: Date: Employee Signature/Witness Date: