

**PATRICK M. KANE, M.D., P.A.**

I believe it is important for my patients to fully understand our Financial Policy and acknowledge that they have read our Notice of Privacy Practices (HIPAA). Please review the Financial Policy below and the separate Notice of Privacy Practices document carefully. To avoid any misunderstanding regarding either policy, it is necessary for you to read both, and sign below, before treatment is rendered. Please ask any questions you may have regarding either document.

**OUR FINANCIAL POLICY**

This policy covers office visits, procedures, lab or other testing performed. By signing below, I am agreeing to the terms of this Financial Policy.

**MEDICARE PATIENTS:** I am a participating physician with Medicare. This means that you will be responsible for the 20% of the approved Medicare fee for covered services, the \$155 yearly deductible and full payment of any non-covered services. Non-covered services include, but are not limited to complete annual physical exams and most diagnostic tests performed for screening purposes. We will provide Medicare with your supplemental (secondary) insurance so that they may file that for you (Medigap policies only). If you do not have a Medigap crossover policy, you will be responsible for filing your secondary insurance.

**PAYMENT IS DUE AT TIME OF SERVICE:** Payment is due in full at the time of service unless you are covered by Medicare or an insurance company with which I participate (please see insurance below). Returned checks will be charged a \$25 service fee, no exceptions.

**INSURANCE:** Patients will be asked to present their insurance card for copying upon check in at the office the first time they are seen for medical services. Please inform us on subsequent visits if your insurance has changed. Claims not paid within 45 days by your insurance company will become your responsibility. You will receive a statement for these services and you will need to contact your insurance company for reimbursement.

For those patients in insurance plans with which I AM a participating provider, all co-payments, deductibles, and non-covered services are due at the time of service. We will file the insurance claim to the insurance company. In the event that your insurance coverage changes to a plan where I am not a participating provider, we will require payment in full at the time of service and we will file with your insurance company as a courtesy. Any charges that are not paid by your insurance are your responsibility. Your insurance policy is a contract between YOU and your insurance company. Any pre-certification of procedures or testing are your responsibility. Please let us know in advance if your insurance company requires this.

**COLLECTIONS:** Please note, if payment is not received from either you or your insurance company within 60 days from the date of services, your account will be considered delinquent and subject to referral to an outside collection agency.

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

I have been given the opportunity to review Patrick M. Kane, M.D., P.A.'s Notice of Privacy Practices (a separate document) prior to signing this acknowledgement. I hereby acknowledge that Dr. Kane may use and disclose my protected health information to carry out treatment, payment and healthcare operations. The Notice of Privacy Practices provides a complete description of such uses and disclosures. Uses and disclosures not listed in the Notice of Privacy Practices will require my prior written authorization.

I may make restrictions to the use and disclosure of my protected health information or revoke a previous request for restriction at any time except to the extent that the practice has already made disclosures in reliance upon my prior authorization to do so. Both Requests for Restrictions and Revocations must be in writing. By signing below I am acknowledging that I have received the Notice of Privacy Practices and understand my rights to modify how my information is used and disclosed. If Dr. Kane determines that my restrictions make it impossible for him to carry out my treatment, payment and healthcare operations, he may refuse to accept me as a patient.

I agree to the Financial Policy and acknowledge that I received the Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

Date: \_\_\_\_\_

\_\_\_\_\_  
Print name of Patient or Legal Guardian