

Patient Responsibility and Practice Policies Acknowledgment

Patient Name: _____ Date of Birth: _____

1. Patient's Financial Responsibility

- I understand that I am financially responsible for my health insurance deductible, coinsurance, copay, outstanding balances or non-covered services.
- All co-payments, deductibles, co-insurance, & outstanding balances must be paid at the time of service. If you have a deductible, a portion may be collected at the time of service, with the remaining balance due at your next visit or upon receipt of a billing statement. If payment in full cannot be made at the time of service, your appointment may be rescheduled.
- I understand that it is my responsibility to notify Hope Integrative Medicine (HIM) promptly of any changes to my billing or insurance information. If an insurance claim is denied due to incomplete, incorrect, or outdated information, I am responsible for payment in full. I understand that insurance claims must be filed within specific time limits, and if a claim cannot be filed timely due to inaccurate information I provided, I will be responsible for the balance. I agree to assist in resolving insurance payment issues when needed and understand that I am responsible for any portion of charges not covered by my insurance plan, including services that may be non-covered by Medicare or other insurers.
- If I am uninsured or self pay, I agree to pay for the medical services rendered to me at the time of service. If I am uninsured or self-pay, I understand that I am entitled to receive a Good Faith Estimate of expected charges upon request.
- I understand that a valid form of payment is required to schedule an appointment and will be securely kept on file as part of my patient record. I authorize HIM to charge my credit/debit card for copayments, coinsurance, outstanding balances, and charges not covered by my insurance. I understand that a minimum of **24 hours' notice** is required to cancel an appointment unless otherwise approved due to an emergency. Missed appointments or cancellations without proper notice will result in a **\$50 fee**, which may be charged to my card on file and must be paid before scheduling a new appointment. I agree not to dispute charges for services rendered or appointments missed in accordance with this policy. You may be discharged if you have more than three missed appointments.
- Patient account balances are due within 60 days of the receipt of the billing statement and must be paid prior to services being rendered. If I am unable to pay my balance in full, my appointment may be rescheduled until payment arrangements have been established. If you have failed to make payment arrangements after two billing statements, your account may be turned over to an outside collection agency. If this is to occur, you will be notified that you have 30 days to find alternative care. During that 30-day period, our providers will only be able to treat you on an emergency basis.
- Requests for completion of medical forms (including, but not limited to, FMLA, disability, and similar documentation) are subject to a \$35 fee per form, in accordance with South Carolina Code of

Laws 44-115-90 and 44-115-110. Payment must be received prior to completion of the requested form.

- I understand that my provider may recommend laboratory testing for preventive or diagnostic purposes, which may be completed at a laboratory of my choosing. I understand that insurance coverage for laboratory services varies by plan, and it is my responsibility to understand my benefits.
- Any laboratory services not covered by my insurance, including amounts applied to deductibles or coinsurance, are my financial responsibility, and I may receive a bill directly from the laboratory.

2. Assignment of Benefits and Medicare/Insurance Authorization to Release Records

- I authorize direct payment of insurance and Medicare benefits to HIM for services provided to me and authorize the release of any medical, diagnostic, and treatment information necessary to my insurer, and Medicare and its agents, governmental agencies, or other entities financially responsible for my care for purposes of payment, precertification, authorization, or referral.
- I consent to participate in Hope Integrative Medicine's comprehensive care program, which may include medical care, remote monitoring, care coordination, and behavioral health integration support as determined by my provider. I designate Hope Integrative Medicine as my care management provider. I will have access to message my care team 24-hours a day via the Comprehensive Care Program SMS text number at (855) 624-1582. I authorize the sharing of my health information for care coordination and understand that services may involve insurance cost-sharing. These services do not replace emergency care — call 911 for medical emergencies. I acknowledge that participation is voluntary, services may be modified based on clinical need, and I may withdraw at any time; however, services already provided may still be billed.
- I authorize HIM to obtain all of my medication/prescription history when using an electronic system to prescribe medications.

3. Practice Communication, Prescription, and Pharmacy Policies

- I understand that non-urgent messages, prescription refill requests, and administrative inquiries will be reviewed and responded to by HIM within 48 business hours (excluding weekends and holidays) via text message, secure email, or telephone, as determined by the practice.
- I understand that urgent or emergent concerns should not be communicated through routine messaging systems and require immediate medical attention by calling 911 or going to the nearest emergency department.
- I understand that prescription refill requests are subject to provider review and may require an appointment.
- I understand that pharmacy changes must be communicated at the time of my appointment. Requests made after an appointment may not be accommodated except in the event of an emergency or pharmacy closure, and may result in delays in prescription processing.
- If my plan requires prior authorization, I must notify my provider and allow at least 48 business hours for processing. Prior authorizations can cause a delay in prescriptions being filled.

Signature of Patient, Authorized Representative of Responsible Party

Date