STATEMENT OF FINANCIAL RESPONSIBILITY
RELEASE OF INFORMATION

Financial Responsibility- I understand that it is my responsibility to provide Terry Reilly with accurate and complete information concerning my primary and secondary insurance benefits, including referral documents from other providers. Current identification and insurance benefit cards will be presented at each office visit. As a courtesy, Terry Reilly will file my claim for me.

I understand that most laboratory tests, except those performed during my visit, are processed by an external third-party laboratory. I understand I will receive a bill or an insurance claim, if applicable, directly from the lab for these services. I understand that my provider may not know the cost of these tests at the time of my visit. If I have questions or concerns about the cost, I may inquire with the laboratory personnel or the nursing staff who obtain my sample. I understand laboratory costs can vary significantly, from relatively low fees for common tests to much higher costs for more complex studies. If I am uninsured and qualify, some laboratories may offer a sliding fee discount based on my income verification, which I can apply for at Terry Reilly's front desk. I understand the sliding fee discount which my family may qualify for at Terry Reilly may be applicable at some but not all laboratories. If I have concerns about the cost or face financial hardship, I will request an appointment with a Terry Reilly patient navigator.

Insurance - Terry Reilly is a participating provider in many insurance plans and will file my claim as a courtesy to me. In order to properly bill my insurance, it is my responsibility to disclose all insurance information including primary and secondary plans, as well as any change of insurance information. Failure to provide complete and accurate insurance information will result in my responsibility for the entire bill. If any of Terry Reilly's providers are not listed in my plans network, I may be responsible for partial or full payment. If Terry Reilly is out of network and my insurance company paysme directly, I am responsible for payment and agree to forward the payment to Terry Reilly's Patient Financial Services immediately.

Co-pays - I understand that payment is expected at the time of my visit. Terry Reilly accepts cash, check and credit card as well as Care Credit for Dental. Payment will include any unmet deductible, co-insurance, co-payment or non-covered charges from my insurance company. If I do not have insurance and qualify for a sliding fee, my copay for services will be expected at the time of my visit. Payments made on the date of the visit are treated as a deposit to my account and will be applied after my visit. If charges for my services exceed my payment I will be billed for the remainder of the balance. Any credits on my account will be applied to outstanding due balances before being refunded to me.

All of my payments made on outstanding balances will be applied to the oldest date of services across all facilities.

Payment Plans - I am aware that if I fall under hardship and need to make payment arrangements, I may do so either by calling Patient Financial Services, in the clinic or online in my portal.

Pre-payment - I understand that prepayment for services is allowed and should be communicated to Terry Reilly when the payment is made in order to ensure it is applied appropriately. Deposits will be held for 3 months at which time any remaining credits on my account will be applied to any outstanding balances with Terry Reilly and the remainder refunded to me.

Nonpayment - I agree to pay any balance remaining on my account. I understand that if I fail to pay the balance on my account, this may result in my balance being turned over to an outside collection service.

Estimates for charges - I understand that any estimate provided to me for charges is just an estimate. Exact costs cannot be determined prior to services and any remaining balance above the estimate given to me will be billed for payment.

Assignment of Benefits - I authorize direct payment of medical benefits to Terry Reilly Health Services. This authorization will remain in effect until cancelled by me in writing.

Release of information - I authorize the release of any medical information necessary in order to obtain payment from my insurance company, Medicare, other physicians or providers, and any other third-party payers and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collections charges considered patient responsibility by my insurance company. I understand that if I am not insured, I am responsible for the charges of the services provided to me. I

understand that if I apply for special programs or other assistance, my information may be shared with those programs and their auditors.

In addition, I understand that information may otherwise be disclosed only in summary, statistical, or other form that does not identify the individual. Reasonable efforts to collect charges without jeopardizing client confidentiality must be made but your confidential health information may be sent to a policyholder where the policyholder is someone other than the client (Title X 42 CFR § 59.10(a)).

MVA/Work Comp - If my visit is due to a work-related injury or auto accident, I am responsible to provide Terry Reilly with the case number or policy number, the workman's compensation or insurance carrier's name, address or other contact information at the time of my appointment. I understand that if my claims are denied or I fail to provide the necessary billing information I will be financially responsible for my bill. Terry Reilly does not bill third party billing for auto accidents. It is my responsibility to open a claim with my auto insurance and provide the necessary billing information for these visits.

Returned Checks -The charge for a returned check is $35 payable by cash, credit or money order. Should my check be returned, I understand that this charge will be applied to my account in addition to the returned insufficient fund amount.

Credit Card Charges: I authorize the release of any medical information necessary to obtain payment from a credit card company in the event of a disputed charge. I understand I am responsible for all charges, late fees, interest, attorneys fees and collections charges necessary to obtain payment in the event of a dispute.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS, AND ANY QUESTIONS THAT I HAD HAVE BEEN ANSWERED BY STAFF TO MY SATISFACTION.

Signature of Patient	Printed Name of Patient	Date

□ Patient is unable to sign because _____ . For this reason, I hereby verify that I have given my consent for general care and treatment on behalf of the above-named patient.

Signature of Legal Representative	Printed Name	Date