FINANCIAL POLICIES

HEALTH MAINTENANCE ORGANIZATIONS (HMO) are those with co-pay per visit. All co-pays are collected at the time of the visit. In order to see you, we must be designated as your PCP with your HMO.

PREFERRED PROVIDER PLANS OR CHOICE OPTION PLANS (PPP, PPO, POS) are plans that allow you to choose your provider. There may be a deductible and/or co-pay collected at the time of the visit. If we are not on your preferred list or are outside the preferred panel the paid benefits may be at a lower percentage (for example 70% instead of 80%). You will be expected to pay the difference at the time of service.

STATE OR FEDERALLY FUNDED PLANS:
If you have state funded insurance such as Molina or DSHA, we will bill the agency for you. Our patient panel is currently closed for patients with these types of insurances. For services which are not covered, you will be asked to sign a waiver and pay at the time of service.

INDEMNITY PLANS are those with deductibles, pay a percentage of the bill and allow you to choose your physician. You are responsible for the amount not covered by insurance.

MEDICARE:
All Providers are participating with the Federal Medicare program, MedAdvantage (Regence Blue Cross Blue Shield), and Secure Horizons. If you have supplemental GAP/PIP coverage, (secondary insurance), we will file claims for your services to both carriers. Deductibles, co-payments, and fees for any non-covered services are due at the time of service. All Medicare patients are required to sign a waiver indicating that they understand that they will be responsible for non-covered services denied by Medicare. I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to CREEKSIDE MEDICAL or the physician on my behalf.

PATIENT RESPONSIBILITY:

- You are responsible for all charges resulting from treatment provided by Creekside Medical. We bill most insurance carriers. However, primary responsibility for the account is yours.
- Your co-payment is always due at the time of service; if co-pays are not paid at the time of service there is a $10.00 billing fee that will be added to your balance.
- Any remaining balance owed by you is due when you receive your first bill, unless other financial arrangements are made. If you have a delinquent balance, we may ask you to make a payment at the time of your next visit with us. Balances due by patients under $2.50 will not be sent a statement due to cost; these balances will be collected from the patient at the next office visit.
- Minors: Patients under 18 years of age will be the responsibility of the custodial parent(s)

INSURANCE BILLINGS:

- It is your responsibility, (or that of the financially responsible party), to provide current, accurate insurance billing information. If your insurance information changes, please provide the new insurance information prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges.
- Medicare: We participate with Medicare. We will bill Medicare as your primary insurer. We will also bill your supplement insurance provider.
- Medicaid: Please bring your current medical card with you to each appointment. If you are restricted to a primary care physician by Washington's Department of Social and Health Services, *you must obtain a referral* prior to receiving care from a specialist.

NON-INSURED PATIENT PAYMENT
If you do not have insurance, we will provide your care on cash for services basis. A $100 deposit is due at the time of the visit for all private pay **new patient** visits. A $50 deposit is due at the time of the visit for all **established patient** visits. Patients will be billed for any remaining balance.

- Non-insured patients will be given a 20% discount off of physician services*.
- (*physician services do not include medications, blood draws, lab work, or administration of immunizations)
- Payment in full at the time of service with cash or check will get an additional 10% discount (for a total of 30%)
- Payment in full at the time of service by credit card, you will get an additional 5% discount (for a total of 25%)

CHECK RETURNED:

It is our office policy to charge a **$40.00** fee for checks that are returned

DELINQUENT ACCOUNTS:

Accounts that become delinquent may be subject to collection activity, and a $20.00 late fee may be added to cover the cost of additional handling required.

PRESCRIPTIONS:

I acknowledge that my treating physician may obtain a prescription history if necessary

Preferred Pharmacy / Location: _____ Phone #: _____

_____	_____	_____
Patient Name (Please Print)	Patient's Signature	Date

IF PATIENT IS UNDER THE AGE OF 18 YEARS, OR IS OTHERWISE UNABLE TO SIGN, COMPLETE THE FOLLOWING:

Patient is _____ year(s) of age or is unable to sign because: _____

_____	_____	_____
Signature	Relationship to Patient	Date

Follow-Up Appointments & Tests/Procedures

Our staff will encourage you to schedule your follow up appointment before you leave, and you will receive an automated reminder call, text or email before your appointment. If you decide not to schedule your follow up appointment when you leave, you are responsible for making your next appointment.

Follow-up appointments and/or recommended tests/procedures are the patient's responsibility. Creekside Medical attempts to notify each patient that your follow-up appointment is due via text or voice message. Please make sure we have your correct phone numbers.

Lab/Imaging Results

We will contact you via the patient portal, phone call or by letter to provide you with any results of tests/procedures. Results will always sent to you, so if you have not received your results within 2 weeks, please contact our office after 2 weeks.

Follow Up Appointment

If you did NOT schedule your follow-up appointment before you left the office, Creekside Staff will attempt to remind you one time via text, voice message or letter.

Non received test/procedure

If Creekside Medical doesn't receive test results when expected, Creekside Staff will attempt to remind you one time via phone, message, text or letter.

Patient Name (Please Print)	Patient's Signature	Date

Laboratory Designation Form

Due to ever changing insurance contracts with various laboratories, we ask that you complete this form designating which lab you prefer to use. Ultimately it is your responsibility to know the benefits of your insurance plan. If you are not sure which laboratory your particular policy is contracted with, please call your insurance company before you leave the office today and let us know.

Example of services that require use of a lab:

- Phlebotomy – blood draws
- Strep Tests / Cultures
- Urine Tests / Cultures
- Pap Smears

Laboratory of Choice

- ☐ Quest –(Services can be provided here in our office)
- ☐ Legacy
- ☐ Peace Health (SWMC)
- ☐ Other: _____

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason. Charges for the lab tests are billed separately and not included in the charges for your physician visit. If you have questions or concerns about your lab bill, you must call the lab directly.

Patient Name: _____ DOB: _____

Current Insurance Provider: _____

Signature: _____ DATE: _____

VERBAL DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

HIPAA (The Health Insurance Portability and Accountability Act) gives you the right to request that we communicate financial and or medical information to you in confidence by a particular method. In order to protect the privacy and confidentiality of your information, please complete the following. This form will tell us how you wish to be contacted and with whom we may discuss your healthcare, insurance and billing questions.

I give permission for (Select Preferred Method):

Confidential messages (such as appointment reminders, normal test results) may be left on voicemail or sent via text.

☐ Cell Phone#_____ Prefer ☐ Text ☐ Voicemail

☐ Home Phone # _____

I hereby authorize Creekside Medical to release PHI to the person(s) listed below: (i.e. spouse, family members, friends, caregiver, etc.).

Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient

I understand that I may revoke this authorization at any time by notifying Creekside Medical in writing and the revocation will be effective on the date noted, except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy regulations.

Patient or legally authorized individual signature Date Time

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

PATIENT NAME: _____ **Date of Birth:** _____

By signing this form, I am acknowledging receipt of the Notice of Privacy Practices of Creekside Medical.

Creekside Medical reserves the right to revise its Notice of Policy Practices at any time. A copy of such revisions is available upon written request.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Printed Name Date