Daniela J. Schupp MD PhD, PLLC

General surgery

Thank you for having chosen our office for your surgical care.

Please read, ask questions if needed, then sign. A copy will be provided upon request.

1. PAYMENT is expected at the time of your visit. We accept cash, checks, or credit cards. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of a driver's license or other form of identification such as a passport or Colorado identity card.

2. INSURANCE We are participating in most insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. **Please remember that insurance is a contract between the patient and the insurance company, and ultimately the patient is responsible for payment in full**. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

Please contact your insurance company with any questions you might have regarding your coverage.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

3. LATE CHARGES of 12% annually will be applied to all patient balances 90 days old or greater.

4. RETURNED CHECKS will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Mesa County.

***5.* ACCOUNTING PRINCIPALS** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

6. FORMS FEES: completing insurance forms, copying medical records, etc... Requires office staff time and time away from patient care for our doctor. We require pre-payment for copying medical records, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $10 per occurrence plus applicable postage or notary fees. Postage is additional and payment is required in advance. Copying fees for Medical Records is $18.50 for the first ten (10) pages and $0.85 per page in excess of ten up to page 40. Pages 41 and above are $ 0.57 per page. Daniela J. Schupp MD PhD, PLLC will have 15 business days in which to copy records before making them available for patients to pick up, and these 15 days will commence after payment for copying has been received and after the patient has signed this form authorizing records' release. In the event that the office is closed for vacation, the 15 days apply to an open and active doctor's office and full staff and the process will be completed while the office is actively seeing patients and is staffed. Insurance forms or work releases that are more than 4 pages long, will require a pre-received payment of $10.

7. BILLING OFFICE: If you have questions in regard to any of your billing statements, our local billing company working with our electronic medical record company, Athena, is Monument Medical Billing, 970-254-1686, option #3.

8. CANCELLATIONS/MISSED APPOINTMENTS/LATENESS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $25 missed appointment fee.

If you have missed three scheduled appointments, you may be subject to termination from this practice.

We expect new patients to arrive 15 minutes prior to their appointment to complete the necessary documents and check-in. If you are more than 10 minutes late for your appointment, we will most likely need to reschedule you.

9. RESPONSIBILITY FOR PAYMENT: **I understand that I, personally, am financially responsible to Daniela J. Schupp MD PhD, PLLC for charges not covered by the assignment of insurance benefits.**

10. ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, transfer, and set over directly to Daniela J. Schupp MD PhD, PLLC sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic and procedures by Dr. Daniela Schupp. I authorize Daniela J. Schupp MD PhD, PLLC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Daniela J. Schupp MD PhD, PLLC. I authorize Daniela J. Schupp MD PhD, PLLC to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

12. SELF PAY PATIENTS OR PROMPT PAY PATIENTS WHO ARE INSURED: A 20% prompt pay discount is applied to all full pay payments received at the time of service

whether or not you carry insurance. This means anyone willing to or needing to pay in full at the time of service will receive the 20% discount off of the evaluation and management service codes only. Daniela J. Schupp MD PhD, PLLC does not make payment arrangements or extend credit. All services are expected to be paid in full at the time of service.

13. RELEASE OF INFORMATION: I hereby authorize and direct Daniela J. Schupp MD PhD, PLLC to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

14. COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, attorney fees, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

15. DIVORCED PARENTS of PATIENTS: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment.

16. PDMP, Colorado's electronic Prescription Drug Monitoring Database (PMP)

If you receive a prescription for a "controlled" (Schedule II through V) drug, your identifying prescription information will be entered into Colorado's electronic Prescription Drug Monitoring Database (PDMP) when this drug is **dispensed** to you. Your prescription information in the database is a protected health record and **cannot** be accessed by non-caregivers except as part of an authorized investigation. You have a right to access your information in the PDMP through the Colorado Board of Pharmacy. You may seek corrections to the information as you would your other medical records.

I have read and understand the practice's financial policy and other policies and I agree to be bound by its terms. I understand and agree that regardless of my insurance status,

I am ultimately responsible for the balance on my account for any professional services rendered. I have provided Daniela J. Schupp MD PhD, PLLC with true and correct insurance information. I will notify you of any changes in my health insurance coverage.

I also understand and agree that such terms may be amended by the practice from time to time.

____ _______________

Signature of Patient/or Guarantor if applicable Date

____

Printed name of signature

____

Please Print the Name of the Patient