extant healthcare

PATIENT FINANCIAL RESPONSIBILITY

PATIENT NAME: _____ DOB: _____

Financial Agreement. (Please initial to attest to each line item)

_____ I acknowledge, that as a courtesy, Extant Healthcare may bill my insurance company for services provided to me. _____I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.

_____Extant Healthcare will submit your claims to your insurance carrier(s) for payment. If we do not receive payment from your insurance carrier(s) within sixty (60) days of submitting your claims, we will send you a Balance Due statement. Upon receipt of this statement, we encourage you to contact your insurance carrier if you believe they should pay for the services, or call us to make payment arrangements for yourself.

_____Any unpaid balances remaining on your Extant Healthcare account more than 45 days after your insurance carrier has paid, may incur a collection charge and be transferred for collection action. Unpaid balances may incur finance charges at the rate of 1.5% per month.

_____Patients without insurance coverage are expected to make payment arrangements with one of our Financial Counselors either before an elective surgery or as soon as possible after an emergency surgical procedure.

_____For patients experiencing financial difficulties, we may establish mutually agreed upon payment arrangements. If payments are made as agreed, no additional fees or interest will be assessed to patient's account.

_____ I understand that there is a $35.00 fee for any returned check.

_____ Disability forms and other forms may incur a processing fee of $15.00 per form.

Third Party Collection. I acknowledge that Extant Healthcare may utilize the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to Extant Healthcare any insurance or other third-party benefits available for health care services provided to me. I understand Extant Healthcare has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Extant Healthcare, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Consent to Telephone Calls for Financial Communications. I agree that, in order for Extant Healthcare or Extended Business Office (EBO) Services and collection agents, to service my account, contact me for appointment reminders, or to collect any amounts I may owe, I expressly agree and consent that Extant Healthcare or EBO Servicer and collection agents may contact me by telephone or email at any telephone number, without limitation of wireless, I have provided or Extant Healthcare or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or any related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Photocopying. A photocopy of this consent shall be considered as valid as the original. By signing this agreement, you authorize Extant Healthcare to photocopy your identification cards, including but not limited to your insurance card and driver's license.

Patient/Patient Representative Signature: **Date:**

_____ _____

If you are not the patient, please identify your Relationship to the Patient. **(Circle or mark relationship(s) from the list below):**

Spouse **Parent** ***Guarantor** **Legal Guardian** **Healthcare Power of Attorney** **Other**_____

*If applies – Must complete Guarantor information on Patient Registration