

Auria Medical Clinics Policies,

1-Financial policy

Effective 1/8/2025

We ask that all our patients read, understand, and accept our Policies, as described below, if they agree. By completing, signing, and submitting this document, I consent to have read, understood, and agreed to the following policies. I had the opportunity to attend the practice to ask any questions, if necessary, for clarification of the following policies. I can download a copy of these policies online and keep them in my records.

1-Financial Policy

----- **Initials:** It remains my responsibility to verify that Auria Medical Clinics, LLC, the practice, is in my insurance network; if I fail to verify that, then it is my responsibility to pay all the applicable charges upon request.

___ **Initials:** I consent that I am responsible for all charges assigned to me by my insurance, to include, but not limited to, yearly deductibles, co-insurances, co-pays, non-plan coverages, and all charges/treatments not covered by my insurance.

___ **Initials:** The amount collected today is an estimate only. This is based on initial available insurance information and does not reflect the final balance. After your insurance processes the claim, you may be billed for any remaining balance. If the final insurance payment results in overpayment, you will be issued a refund. The credit amount may be applied to your future visits.

___ **Initials:** Please note that deductibles are determined by your insurance and not by us. Deductibles are collected in full at the time of your visit. Typically, deductibles for consultations are separate from deductibles for procedures.

___Initials: Deductibles if NOT met:

New patients are charged \$250, and follow-up visits are charged \$180.00.

All procedure fees are due in Full at the time of the visit.

___ **Initials:** You will be charged \$50 for any bounced back checks or credit card transactions in addition to the owed principal.

___ **Initials:** If I fail to cancel my appointment 48 hours in advance, I will be charged \$50 no-show fee.

___ **Initials:** Administrative fees:

I agree to pay the following administrative fees if applicable:

- Prior authorization that takes less than 60 minutes: \$30.00
- Prior authorization and appeals that take more than 30 minutes and consume the physician's time: \$100.00

- Requesting an electronic copy of your chart mailed to you or any other third party upon written request: \$25.00
- Requesting a paper copy of your chart mailed to you or any other third party upon written request: \$25.00 Base fee plus \$0.99 for pages 1-20, \$0.83 for pages 20-100, and \$0.66 for pages 100+
- Requesting a notary public to mail any legal affidavit to your lawyer, which involves our physician's time out: \$300.00, plus mailing fee.

___ **Initials: Medicare beneficiaries** are responsible for paying an annual deductible and, if applicable, 20% or more coinsurance.

___ **Initials:** If we do not have a contract with your insurance carrier, we cannot accept an assignment for reimbursement by your carrier. Therefore, charges are due and payable by you at the time of service. You receive a receipt to submit to your insurance as you will.

___ **Initials:** If the patient has a guardian or chaperone, that person or entity is financially responsible for our charges.

Billing and Collection Policy:

___ **Initials:** I understand that:

The practice uses Healow Statement services. Within 7 days of receiving your insurance reimbursement, if there is any balance, you will receive a payable statement through your phone messenger, voice message, and email with links to pay.

If you fail to make the first request within 7 days, you will receive a printed statement in the mail every 2 weeks for 2 payments. There are links to pay the balance. If you fail to pay again, then the balance will be forwarded to a collection agency.

In addition to paying the balance to the collection agency, you will be charged 25% of the collected balance.

Name:

DOB:

Signature:



Credit Card on File Authorization and Consent

Patient Name: _____

Date of Birth: ____ / ____ / ____ MRN (if applicable): _____

Date: ____ / ____ / ____

Purpose

I authorize [Practice/Clinic Name] (“Practice”) to store my payment card information in a **secure, encrypted payment vault** (“safe vault”) maintained by the Practice and/or its designated payment processor, and to use that payment method for charges as described below.

What I Am Authorizing

By signing this form, I authorize the Practice to charge my card on file for any of the following, as applicable:

- Copayments, coinsurance, and deductible amounts
- Outstanding balances after insurance adjudication (including patient responsibility)
- Non-covered services, self-pay services, and other patient-pay amounts I have agreed to
- No-show/late cancellation fees, if applicable per Practice policy
- Payment plan installments, if applicable and agreed upon

How My Card Information Is Stored

- My card information will be stored in a **secure payment vault** (“safe vault”) and not written on paper or stored in an unencrypted format within the office.
- For security, the Practice may store a **tokenized reference** to my card rather than the full card number.
- The Practice will follow applicable privacy and security standards to help protect my information; however, **no system can be guaranteed to be 100% risk-free**.

Receipts and Notifications

- I may request a receipt for any transaction (paper and/or electronic, where available).
- If the Practice sends electronic notices (text/email), standard messaging rates may apply.

My Choices and Rights

- I may revoke this authorization at any time by submitting a written request to the Practice. Revocation will not affect charges already incurred or services already provided.

- I agree to notify the Practice promptly if my card changes, expires, or is replaced.

Patient Acknowledgment

I have read and understand this authorization. I agree that I am financially responsible for applicable patient-pay amounts and authorize the Practice to store my card in a secure vault and charge it as described.

Cardholder Name (print): _____

Relationship to Patient (if not self): _____

Signature: _____ **Date:** ____ / ____ / ____

Phone: _____ **Email (optional):** _____

HIPAA Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal law that mandates all medical records and other individually identifiable health information—whether maintained electronically, on paper, or orally—be kept strictly confidential. This Act provides you, as the patient, with important rights to understand and manage how your health information is used. HIPAA also establishes penalties for covered entities that misuse personal health information.

As required by HIPAA, this notice explains our legal obligations to maintain the privacy of your health information and how we may use and disclose it.

We may use and disclose your medical records only for the following purposes:

- **TREATMENT:** Providing, coordinating, or managing health care and related services among one or more health care providers. For example, coordinating teeth cleaning services.
- **PAYMENT:** Activities such as obtaining reimbursement for services, confirming coverage, billing, collections, or utilization review. For example, sending a bill to your insurance provider for payment.
- **HEALTH CARE OPERATIONS:** Business activities necessary for running our practice, including quality assessment and improvement activities, auditing, cost management analysis, and customer service. For example, conducting an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to personally identifiable data.

Additionally, we may contact you with appointment reminders or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You have the right to revoke such authorization in writing, and we are obligated to honor and comply with your request, except to the extent we have already acted in reliance on your authorization.

You have the following rights with respect to your Protected Health Information (PHI), which you may exercise by submitting a written request to our Privacy Officer:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, relatives, close personal friends, or any other persons identified by you. While we are not required to agree to the requested restriction, if we do agree, we must comply unless you authorize its removal in writing.
- The right to make reasonable requests to receive

confidential communications of PHI from us through alternative means or at alternative locations.

- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to obtain a paper copy of this notice upon request.

We are legally required to maintain the confidentiality of your PHI and to provide you with notice of our legal duties and privacy practices regarding your PHI.

This notice is effective as of February 1, 2009. We are required to adhere to the terms of this Notice of Privacy Practices and to apply the new notice provisions to all PHI we maintain. We will post and, upon request, provide you with a written copy of any revised Notice of Privacy Practices. Retaliation against individuals who file a complaint is strictly prohibited.

For more information about HIPAA or to file a complaint, contact:

U.S. Department of Health and Human Services
Office for Civil Rights

Independence Ave SW, Washington, DC
1-877-696-6775

PRACTICE PROCEDURES AND POLICIES

Patient Information

Date:

Name:

DOB:

Practice Procedures

Important practice procedures and policies are outlined below. Please read each point carefully and initial where indicated to acknowledge your understanding.

- _____ **Initials:** I understand that I must allow at least 72 hours for prescription refills.
- _____ **Initials:** I understand that a follow-up visit with my physician may be required to obtain additional refills of my medications.
- I agree to take all medication(s) exactly as instructed.
- _____ **Initials:** I understand that I am not permitted to change the dosage or alter the timing of my medication(s) without first consulting my physician. I also understand that narcotic medications will not be called after hours, on holidays, or on weekends.
- _____ **Initials:** I must keep all appointments as recommended. If I miss an appointment three times without notifying the practice in advance to cancel, I will be responsible for a no-show fee for each time, and the practice reserves the right to discharge me as a patient.

Appointment and Cancellation Policy

I understand that Auria Medical Clinics requires at least 48 hours' notice to cancel or reschedule a follow-up or test appointment. Failure to comply with this policy may result in a charge, and I will be responsible for paying the current no-show fee.

Insurance and Payment Responsibilities

I am aware that I am responsible for following my insurance company's requirements regarding referrals or pre-authorization. If I do not comply, I will be responsible for full payment of services.

I also understand that I am responsible for any co-payment due at the time of service and any other amount not covered by my insurance company.

I authorize Auria Medical Clinics to release any necessary information to insurance companies for payment of medical services. A copy of this authorization is as valid as the original.

Returned Checks and Collections

I am aware that there will be a \$50.00 fee for any check returned by my financial institution.

If my account is sent to a collection agency, any additional charges or legal fees incurred will be added to my account balance.

Practice Termination Policy

Termination:

A patient may be discharged from the practice with 30 days' notice for noncompliance with these policies.

The following actions are grounds for immediate termination:

- Obtaining narcotics from another physician while under the care of our physicians or altering or forging a prescription. This is a federal felony, and it will be reported to authorities.
- Using inappropriate language or behaving violently, whether over the phone or in the office.

Acknowledgment

I have read, fully understand, and agree to the policies stated above.

Sign:

Date: