Financial Agreement & Notice of Privacy Policies

Quality care for our patients is our priority. Please take a few minutes review the financial agreement and notice of privacy policies and sign at the bottom of the form. If you have any questions please let us know.

Personal Information

First Name	Last Name	Middle	Date of Birth
_____	_____	_____	_____

Financial Policy Agreement

Rolling Hills is committed to providing the highest level of professional medical/dental care and personal service. For every commitment there is an obligation to provide quality care and service. Conversely, it is the patient/guardian's responsibility to meet their financial obligation.

Since our clinic accepts many different insurance plans, it is impossible for us to know all covered benefits, co-pays and deductibles for each plan. While it is our intention to assist you, it is still your responsibility to insure that all services rendered by Rolling Hills Clinic on your behalf are paid in full.

For patients whose insurance is provided by a plan with whom we contract, we will submit the insurance claim, but our office expects same day payment of all co-payments, deductibles and non-covered services.

_____ Treatment plans may change; I understand that I am responsible or work actually done.

_____ I understand that if I begin a major treatment that involves lab work, I will be responsible for the fee at that time.

_____ If I am sent to collections, I agree to pay all related fees and court costs.

_____ I agree to pay a finance charge of 1.5% per month (18%) APR on any balance 90 days past due.

It is important that you bring proof of insurance each time you visit the clinic. Failure to do so may result in you not being seen or being required to make full payment at the time services are rendered. Rolling Hills Clinic accepts cash, check or major credit cards. Proof of eligibility for Medicare, MediCal, and contracted insurance companies is the responsibility of the patient. If the insurance carrier reports the patient is not eligible, the patient is responsible for full payment of charges even if litigation is pending. Please make every effort to let us know if your insurance (primary **or** secondary) or your personal information (home address, employer, or phone number) has changed since your last visit.

We understand that insurance coverage is very confusing to many people, and we are committed to helping you with any questions you may have. Please feel free to call our office. In cases where patients are required to pay cash for an appointment (due to complications with insurance cards etc.), a close approximation of the cost must be paid on the day services are rendered. Should the actual cost of the treatment amount to a different amount, the difference will be either billed or refunded to the patient.
I have read and understand the policy stated above.

Authorization for Release and Assignment of Benefits

Release of Benefits and Information: I authorize my insurance benefits to be paid directly to the Rolling Hills Clinic. I am financially responsible for any balance due. I authorize Rolling Hills Clinic to release any information required for processing of a claim. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

	_____ Date
_____ Guarantor/Responsible Party Signature	_____ *Print* Guarantor/Responsible Party Name

Medicare Authorization

I request that payment of authorized Medicare benefits be made on my behalf to the Rolling Hills Clinic for any services provided to me. I authorize any holder of my medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible amounts are based upon the charge determination of the Medicare carrier. I have read and understood Rolling Hills Clinic's Medicare Authorization as described above.

Notice of Privacy Policy

I have had full opportunity to read and consider the contents of the HIPAA Notice of Privacy Practices. I understand that I am giving my permission to the clinic for disclosure of my protected health information pertaining to my medical and dental treatment. The purpose of this information is to provide the patient with the best care possible pertaining to their medical and dental treatments, referrals, prescriptions, payment activities, and healthcare operations. Your information will not be sold to outside companies. I also understand that I have a right to revoke this permission at any time.

By supplying my home phone number, mobile phone number, email address, or any other personal contact information, I authorize Rolling Hills Clinic to employ a third-part automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments and leave a reminder message on my voicemail or answering system if I am unavailable at the number provided by me.

I understand that this information may also be used to contact the patient for appointment reminders for medical or dental care at the clinic. I give my permission for the clinic to leave messages with persons or voicemail machines at the phone numbers I have provided.

Patient information may be released to the following persons listed below:

Name	Relationship
_____	_____
_____	_____
_____	_____

I have read and understood Rolling Hills Clinic's Notice of Privacy Policy as described above.

_____
Date

_____ _____
Patient or Guardian Signature *Print* Patient or Guardian Name

---

Official Use Only:

Proof of Guardianship Received ☐ ☐
Scanned/Copied to Chart ☐ ☐

_____ _____
Signature of Witness Date

Patient refused or denied to sign ☐
Communication barrier prohibited obtaining acknowledgement ☐
Emergency situation prevented us from obtaining acknowledgement ☐