D. JOEY BARRIOS III MD
GENERAL SURGERY

Financial Policy

Patient Name: _____ **Pt Initials Acknowledgement of 1st page: _____**

This is an agreement between Dr. Dave J. Barrios, III, APMC, as creditor, and the Patient/Debtor named on this form.

In this agreement, the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to Dr. Dave J. Barrios, III, APMC.

By executing this agreement, you are agreeing to pay for all services that are received.

Regarding Insurance:

Contracted Insurance: We accept most insurance plans. If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or co-insurance, you must pay at the time of service. It is the insurance company that makes the final determination of your eligibility. Your insurance policy is a contract between you and your insurance company. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it.

Non-Contracted Insurance: Insurance is a contract between you and your insurance company. If we are not contracted with your insurance company, you are responsible for payment of these services when rendered and we will file your claim to your insurance company as a courtesy. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by the insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it.

No Insurance: If you do not have insurance, payment is required at time of service.

Surgical Services: We realize that larger surgical fees may be more difficult to pay in one lump sum. Prior to your surgery, our office staff will discuss surgery charges and pre-surgery payments that may be required. A pre-surgery deposit may be required, depending on your coverage. A cost estimate, which shows your financial responsibility based on the benefit levels and coverage of your insurance plan, will be explained. All surgery deposits must be paid prior to the date of your surgery or your surgery will be canceled with the hospital. If you choose to cancel your surgery for any reason less that 2 days before your scheduled surgery date, you will forfeit your surgery deposit and it will not be refunded.

Our office will prepare and submit a claim to your insurance carrier. Please ensure that we have your current insurance information on file. You should understand that this is done as a courtesy. Because our services are rendered to you, not your insurance company, you are ultimately responsible for payment of these services. This includes those services that your carrier may not cover.

Payment Options: We accept most major credit cards, cash and checks. Checks are not accepted for surgery deposits.

Monthly Statements: After your services, you will receive a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month. Unless other arrangements have been approved by us in writing, the balance on your statement is due and payable in full when the statement is issued. If this is not possible, our office manager will be happy to discuss specific payment arrangements with you.

Discounts/Special Arrangements: Any special discounts or special arrangements approved by our office must be in writing by Dr Barrios.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Past Due Accounts: Because our office manager is available to assist you when finances become a problem, our office will take appropriate action if your account becomes past due without valid reason. Accounts that are 90 days past due may be subject to further collection action. Possible actions may include credit reporting and/or legal pursuit of payment. If we have to refer collection of the balance to an attorney, you agree to pay all attorneys' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Lafayette, LA.

Returned Checks: There is a $25 fee for any check returned by the bank. If more than one returned check is received on your account, we will require that future payments be made by cash, cashier's check or credit card. If you do not bring in payment for the check and returned check fee, the check will be filed with the District Attorney's office for collection. All fees incurred in the filing will be your responsibility as well.

Medical Leave/Disability Forms: There is a $20 cash fee for each form that needs to be completed. We require 5-7 business days to complete any form. Payment is due upon completion of forms.

Medical Records: If needed, an initial copy of your medical records will be available to you. If additional copies are needed, there will be an additional charge of $1 per page.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is authorizing parent's responsibility to collect from the other parent.

Co-Signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all terms and conditions contained herein and the agreement will be in full force and effect.

I understand that payment is due at the time of service or pre-operative appointment. I understand that I am responsible for any outstanding balance. I have read and understand the above financial policy.

Patient Name: _____ Responsible Party: _____
(If not the patient)

Signature: _____Co-Signature:_____

Date: _____ Date:_____