Financial Policy and Disclosure

This Financial Policy and Disclosure is to help us provide the most efficient and reasonable healthcare services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment of services provided to patients.

Patients are responsible for the payment of all services provided by Grove Medical Associates, P.C.

Self-Pay Policy:

- If you are a self-pay patient, you will be required to pay for all services prior to the services being rendered.
- In addition, any outstanding balance on your account will be requested upon check-in of your next appointment.

Group Insurance Policy:

- If you are a patient who has insurance coverage, it is our policy to bill your insurance first as a courtesy to you, if we have your accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you may be the responsible party for the entire balance of services rendered, and will be billed for the service accordingly.
- Copayments will be collected prior to the rendering of services and are the responsibility of the patient. Copayments that are not received at the time of service are subject to an additional $15.00 service fee. Deductibles and coinsurances will be billed in accordance with the processing of your insurance claims.
- In certain cases, we may require your assistance in contacting your insurance company for payment of services rendered.
- A $20.00 service fee will be charged for all returned checks.

Worker's Compensation Financial Policy:

- If you are a patient being evaluated under a Worker's Compensation case, it is our policy to bill your employer or the Worker's Compensation carrier for services rendered. Upon verification of the status of your Worker's Compensation claim, and completion of your insurance forms, Grove Medical Associates, P.C. can accept assignment of your claim. This information must be provided on the date of your first treatment.
- If you are covered under a Worker's Compensation case, we will accept payments from the Worker's Compensation carrier as per contracted rates based on the mandated Massachusetts state fee schedule.
- If payment is denied from your Worker's Compensation carrier, you may be the responsible party for the entire balance of services rendered, although we will make every effort to bill your medical insurance carrier.

Motor Vehicle Accident Financial Policy:

- If you have been involved in a motor vehicle accident, Grove Medical Associates, P.C. requires the insurance information of the vehicle in which you were riding. This information must be provided on the date of your first treatment.
- If payment is denied by the motor vehicle insurance, you may be the responsible party for the entire balance of services rendered, although we will make every effort to bill your medical insurance carrier.
- I hereby authorize any motor vehicle insurance payment directly to Grove Medical Associates, P.C. This authorization supersedes any and all other assignment of benefit claims including those of my Attorney.

Outstanding and Credit Balances Policy:

- All outstanding patient balances will be sent to a collection agency.
- All accounts sent to the collection agency will be charged a $15.00 collection fee **in addition to** the account balance.
- One of the following must be present for all patients with outstanding balances PRIOR to scheduling another appointment:
    1. A signed payment agreement and full compliance with monthly payment arrangements.
    2. Payment in full PRIOR to your next scheduled appointment.

Please note: If at any time your account is not in good standing, the practice reserves the right to cancel or reschedule your visits. If all attempts at collection fail, a patient may be discharged from the practice.

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Financial Policy and Disclosure cont.

Cancellation and No-Show Appointment Policy:

- **The Grove Medical Associates, P.C. Cancellation and No-Show Policy states that a $40.00 service fee will be charged for all appointments not cancelled with a 24-hour notice to the practice or for all appointments not attended in which no attempt at cancellation is made. This Cancellation and No-Show Policy is posted in the office.**
- Three No-Show appointments may result in the inability to schedule any further appointments with any provider at Grove Medical Associates, P.C. and may result in termination from the practice.

By signing below, I acknowledge that I have read and understand the terms of the Grove Medical Associates, P.C. Financial Policy and Disclosure and agree to abide by the policies as described:

Patient or Authorized Person's Signature Date

Consent for Billing

I do hereby agree and give my consent to the providers at Grove Medical Associates, P.C. to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical and mental conditions.

I understand this treatment may include in-person visits, consultation and treatment via telemedicine that includes two-way communication, telephone calls and portal communications. Copayments, coinsurance and deductibles for all services are determined by your insurance carrier.

Assignment of Benefits

I authorize Grove Medical Associates, P.C. to initiate a complaint to the insurance commissioner for any reason on my behalf.

I request that payment of authorized Medicare and/or other medical insurance company benefits be made on my behalf to Grove Medical Associates, P.C. for any services rendered to me. I authorize Grove Medical Associates, P.C. to release any information needed to determine these benefits or the benefits payable for related services to the Centers for Medicare & Medicaid Services (CMS) and/or other medical insurance company and their authorized agents.

To assist Grove Medical Associates, P.C., I agree to:

1. Provide my current demographic information and insurance carrier information.
2. Provide a current photo identification card and insurance card when changes are made.
3. Make the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or the entire amount if I am a Self-Pay patient.

Patient or Authorized Person's Signature Date

Print Patient Name Patient Date of Birth