Consent to Treat & Financial Policy

Welcome to Saline Medical Specialties! Please read the following information regarding our financial and billing policies. If you do not have medical insurance, we require $100.00 at the time of service for new patients and $80.00 for established patients. If you choose to pay for your visit in full, we offer a 20% discount off the total bill. Our office accepts cash, personal checks, Visa, Mastercard, Discover and American Express.

If you have active medical insurance coverage, we will file claims on your behalf. By providing us current, accurate insurance and policyholder information, you authorize any of our services to be paid to Saline Medical Specialties. If a co-payment is required, it must be paid on the day of your appointment. Not all services may be covered by your medical insurance. Many insurance companies require pre-certification or referrals to a different facility. It is your obligation to know what benefits are covered under your insurance plan. After your insurance has processed a claim submitted by our office, it is your responsibility to pay any remaining balances owed.

If your visit is a work-related injury, your claim will be sent to a workman's compensation carrier or be paid directly from your employer. It is important that you complete all necessary paperwork to allow us to release any information to your employer and insurance carrier. If your visit is due to a motor vehicle accident or other third-party liability accident, we require that you pay for any services at the time of your visit in full. In the case of a divorce or other living arrangements, the custodial parent is responsible for all payments. Saline Medical Specialties will not be involved in disagreements between the parties. You may be billed by other professional services such as laboratory, radiology or by entities such as Physician Lab, Advanced Medical Imaging or others for medical services provided. Accounts not paid in full within 30 days are considered past due. We charge additional fees for returned checks and use a collection agency as necessary. If you cannot make regular payments, it is your responsibility to contact our office to discuss personal payment arrangements.

Consent to Treat:

I, _____do hereby voluntarily consent to any medical, surgical, diagnostic procedures or hospital care provided by Saline Medical Specialties Physicians, Physician Assistants, Nurse Practitioners or physician's designees as necessary in his or her judgment. I acknowledge that no guarantees have been made to me as to the result of treatments or examination in this medical office.

Communications Consent:

By providing any telephone number(s), I expressly consent to receiving communications from Saline Medical Specialties, its staff, contractors, collection agents and others. I understand that depending on my personal phone plan, I could be charged for any of these phone calls or text messages. I agree to provide new number(s) if my number(s) change. By providing these numbers is not a condition of receiving healthcare services.

Pharmacy Health Information Exchange:

I consent to Saline Medical Specialties to obtain any medication history electronically though a pharmacy health information exchange (e.g. Surescripts, E-Prescribe). Physicians and providers can access the information to know what medications I am taking so that they can treat me appropriately and avoid adverse drug reactions.

By signing, I agree to comply with all policies in this document

Patient or Authorized Signature:_____**Date:**_____

Relationship: _____

Medicare Authorization (Medicare Patients Only)

I request that payment of authorized Medicare benefits be made either to me, or, on my behalf, to Saline Medical Specialties for any services furnished to me by their providers. I authorize my holder of medical information about me to release to the Centers for Medicaid and Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related services. I herby authorize payment of my Medigap and/or Secondary Insurance benefits to Saline Medical Specialties for all claims filed on my behalf. This authorization applies to all services until is revoked by me or my representative in writing.

Patient or Authorized Signature:_____**Date:**_____

Relationship: _____

Updated: 04/2019