HealthVisions MD, Inc.
1230 Alverser Drive, Suite 100, Midlothian, VA 23113
804-893-7800 Fax: 804-893-7801

Financial Policy

This is an agreement between HealthVisions MD, as creditor, and _____, as guarantor.
(please print name)

In this agreement the words "you", "your", and "yours" mean guarantor – patient, caregiver, or entity responsible for the payment of the account. The word "account" refers to the account that has been established in your name to which charges are made and payments are credited. The words "we", "us", and "our" refer to HealthVisions MD.

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

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show, separately, the previous balance, any new charges, finance charges, and any payments of credits applied to your account, during the month.

Non-Insured Patient Policy: HealthVisions MD recognizes patient healthcare is a right and a priority. We recognize events occur whereas you may no longer have health insurance. Therefore, the following guidelines are established for self-paying patients:

- For a short office visit, $100 deposit is expected on the day of service. When you check out, if your charges did not equal or exceed $100 you will be given back the difference. If your visit results in a balance, we ask you to pay by cash, personal check or debit/credit card. If needed, you may also speak to the business office regarding a payment plan.
- For extended office visits and complete physicals, $250 deposit will be due at check-in.
- The above fees do not include lab work/blood draws that may be necessary for your visit. We will do our very best to work with you to set up payment plans for these charges as well.

Insured Patient Policy: You choose to pay your deductible and any previous out-of-pocket portions owed at the time of services rendered by cash, check or credit card.

- If your insurance carrier requires lab work and/or testing be sent to a designated lab or facility, it is your responsibility to notify us upon check-in. Failure to do so may result in out-of-network charges.
- If your insurance plan requires you to see a specific provider, please notify the receptionist upon check-in.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to that contract. In most cases, we will bill your primary insurance company as a courtesy to you. 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 insurance. If your insurance company requires a formal referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment from the insurance company.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. This is a contractual agreement; therefore, we cannot bill you for these.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at time of service.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of one and one-half percent (1.5%) per month or an ANNUAL PERCENTAGE RATE of eighteen percent (18%). The finance charge on your account is computed by applying the periodic rate (1.5%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago and subtracting any payments or credits applied to the account during that time. The minimum finance charge is $0.50.

Returned Check: There is a fee for any check returned by the bank. The current returned check fee is $40.
You may not schedule any further appointments until the returned check fee and check amount have been paid by cash, credit card or money order. Going forward, all payments must be paid by cash, credit card or money order.

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Missed Appointment: Patients who do not show up for a scheduled appointment or cancel with less than 24 hours-notice may be charged a $25 fee. If this appointment is for an extended office visit or physical exam the fee is $75. This fee must be paid before a new appointment is scheduled.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we refer collection of the balance to a lawyer, you agree to pay the lawyer's entire fee, which we incur, plus all court costs. In case of a suit, you agree the venue shall be in Chesterfield County, Virginia.

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 agency, then the fact that you received treatment at our office may become a matter of public record.

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 the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to sign a medical release form, if you want copies of your records sent to another doctor or organization. You authorize us to include all relevant information. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information. You may be responsible for a reasonable copying fee. The current Virginia rates are $0.50 per page for the first 50 pages and $0.25 per page after 50 pages.

Workers Compensation: We require written approval/authorization by your workers compensation carrier and/or employer prior to your initial visit. If your claim is denied, then you authorize us to file to your personal insurance company. If your claim is denied, you will be responsible for any and all charges incurred.

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

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 changes.

Notification: You authorize this office or its agents to contact you at any of the telephone numbers listed by you including cell phones for this account.

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.

Guarantor Name (please print)	Co-Signature Name (please print)	Authorized Representative Name
Guarantor Signature	Co-Signature Signature	Authorized Representative Signature
Date	Date	Date

If you are signing on behalf of a minor, incapacitated or otherwise legally dependent patient, please sign as the "Authorized Representative" and indicate your relationship to the patient. By signing this form as "Authorized Representative" on behalf of the patient, you represent to HealthVisions MD that you have legal authority to act on behalf of the patient.

Authorized Representative's Relationship to Patient