Renaissance Reconstructive & Aesthetic Surgery, INC.

Matthew M. Akers, M.D. Melissa Berger, PA-C
2300 W. Elm Street ~ Lima, OH ~ 45805
Phone: 419~228~8500 Fax: 419~228~8700

Patient Financial Policy ~ Privacy Practices

This is an agreement between Renaissance/Dr. Matthew M. Akers and the Patient/Debtor (Account) named on this form. The account is established in your name to which charges are made and payments credited.

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

Payment for ALL services (including, but not limited to copays/deductible) are due in full at the time services is rendered. We accept cash, checks and most major credit cards. Any payments you receive, for our services, must be forwarded to our office.

Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your insurance as a courtesy to you. As a private entity, we do not contract with all insurances. If you chose to be seen in our office with an out of network insurance, we will bill your insurance ONLY one time and you are responsible for ALL charges/services rendered. Although we may estimate what your insurance might pay, it is your insurance company that makes the final determination of your eligibility and covered services. Not all services area a covered benefit in all contracts. You agree to pay any portion of the charges not covered or paid by your insurance. We ask that you understand your policy and be sure you are fully aware of any limitations of benefits provided. If your insurance requires a referral and/or authorization, our office will be happy in assisting to pre certify outpatient services. **You are responsible for checking with your insurance regarding appropriateness/medical necessity.** Failure to obtain a referral and/or preauthorization may result in lower payment by your insurance and then the charges are owed/responsibility of you. We do not submit to any tertiary insurances.

We only accept <u>standard</u> Medicaid if it is secondary to Medicare. You MUST present your Medicaid card on the date service is rendered or your account will be considered self-pay. We will NOT due any retro claims submission to Medicaid of any kind and all outstanding balance will be patient responsibility.

If you do NOT have insurance, we require that $175 deposit before scheduling a new patient appointment. This fee is for this consultation only, any additional visits are at the discretion of the billing office. All additional services/procedures the patient will be provided with pricing and this must be paid in full before services will be rendered. You will receive a separate invoice for Pathology, lab fees, facility, anesthesia etc. are above and beyond our office pricing and are the patient responsibility.

Cosmetic visits/procedures are NOT covered by insurance. A new cosmetic consultation, we require a $100 deposit before scheduling an appointment. All additional appointments/consults for new services require $50 deposit before scheduling.

For any patient under 18 or 18 and older and still covered by parents insurance, we MUST have authorization form the policy holder of the insurance before rendering any/all services. 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 the time of service.

If you area being treated as part of a personal injury lawsuit or claim, you will be considered as a self-pay patient. All required payment will be the patient's responsibility and we cannot bill your attorney for charges incurred due to personal injury/claim.

Patient obligation Fees: Patients who do not show on time for an appointment or cancel with less than (2) full business days notice will be charged as follows: $50 for new patients visits and $25 for follow up visits. Cosmetic consults will be charged the entire office visit deposit. The visit will not be rescheduled until this fee is paid in full or a new deposit is made. There is a fee (currently $25) for any checks returned by the bank. Administrative fees of $50 may be applied for excess work in filing insurance/claim appeal. Prescription refills requested outside of your appointment will incur $10 charge. There is a $15 charge for each form the office is required to complete for disability, cancer policies or any other forms. The office has a policy of 10 business days to complete these forms. The forms will not be filled out until the form fee is paid. If you reschedule a medical procedure once it is scheduled or rescheduled more than one week prior to surgery there will be a $100 service fee. Cancellation/reschedule of a medial procedure less than one week prior to the procedure there is a $250 fee. These must be paid prior to any rescheduling. Cancellation of a cosmetic procedure at any time, the fee is at the discretion of Renaissance Reconstructive & Aesthetic Surgery, INC. All additional Cosmetic policies area outlined in the Cosmetic Price Quote guidelines.

All of the above mentioned fees cannot be billed to insurance and will be patient responsibility. ** A fee may be waived for circumstances beyond your control such as hospitalization, death or illness, auto accident in transit or hazardous conditions. We do reserve the right to require documentation supporting your reason.

If you need to transfer of your records, the request will need to be in writing and you will pay a reasonable copying fee to have copies of your records sent to another physician/organization. You authorize us to release all relevant information including payment history. If you are requesting records to be transferred to us from another physician/organization, you authorize us to receive all relevant information including payment history.

Unless Renaissance approves other arrangements in writing, the balance on your statement is due and payable in FULL when the statement is issued, and is past due if not paid within 30 days of the office sending the statement. Any accounts over 60 days past due will incur a 5 % finance charge of the outstanding balance per month. If your account becomes past due, we will take necessary steps to collect the debt. If your account is referred to a collection agency, you agree to pay all the collection costs that are incurred and your account will no longer be handled in our office. You also will not be able to return to our office as a patient for any further services. If we refer the collection of your balance to a lawyer, you agree to pay all lawyer fee which we incur plus court costs and agree the venue will be in Allen County.

You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by any telephone number associated with your account, including wireless numbers, which could result in charges to you. We may contact you by text messages and/or email you provide to use. Methods of pre recorded/artificial voice messages and/or automatic dialing services, as applicable. I have read this disclosure and agree Lender/creditor may contact me as described above.

If another person signs this or any other policy of our office, that person takes full responsibility for charges/services/claims rendered to the patient. The co-signature remains in effect until cancelled in writing. If written cancellation is received, it will be effective for subsequent charges only and the co signer remains responsible for all outstanding charges.

In order to submit an insurance claim for services covered under your policy, we must have authorization to release medical information to your insurance company.

I certify that the information provided by me for insurance coverage is correct. I authorize, Renaissance Reconstructive & Aesthetic Surgery, Inc. or any holder of medical or other information about me to be released to Medicare/my insurance carrier or its intermediaries for all covered services rendered by the physician/ or assistants. I authorize my insurance carrier or its intermediaries to issue payment directly to the physician rendering the covered services. I understand I am financially responsible for all charges not covered by this authorization.

I acknowledge that I have reviewed the HIPPA Privacy Act at Renaissance Reconstructive & Aesthetic Surgery, Inc.

I have received the Practice Financial Policy.

I authorize the person(s) listed below to receive all health information about my appointments, treatment and/or other information pertinent to my healthcare and/or payment for any/all services provided by Renaissance. We may contact the person(s) by phone, leaving a message, email or written communication.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

By signing this form, I acknowledge the disclosures, privacy practices and financial policies of Renaissance.

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

Patient Name: _____

Responsible Person: _____

Date: _____

Signature: _____

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Today's Date _____

Name _____ **MI** _____ **Last** _____

Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Cell # _____

Social Security # _____-_____-_____

Marital Status _____

Ethnicity _____

Preferred Pharmacy _____

Town/City _____

Occupation _____

Employer _____

Business Address _____

Business Phone _____

Referring Physician/Person _____

Family Physician _____

Cardiologist _____

Primary Language _____

Email Address _____

Health Insurance *** Must Show Cards***

Primary Carrier _____

Address _____

ID # _____

Group # _____

Policy Holder Name _____

Relationship to Patient _____

Policy Holder Birthdate _____

Policy Holder SSN _____

Policy Holder Employer _____

Secondary Carrier _____

Address _____

ID # _____

Group # _____

Policy Holder Name _____

Relationship to Patient _____

Policy Holder Birthdate _____

Policy Holder SSN _____

Policy Holder Employer _____

Spouse/Emergency Contact

Name _____

Relationship _____

Address _____

Phone _____

Patient Signature: _____ **Date: _____**

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AUTHORIZATION FOR OBTAINING, USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Renaissance Reconstructive & Aesthetic Surgery, Inc. to

(check all that apply):

_____ Obtain the following health information from _____

_____ Disclose the following health information to _____

_____ Use the following health information for _____

This protected health information is being used or disclosed for the following purposes:

Continuity of care, ongoing and/current treatment, payment, and/or operations

This authorization shall be in force and effect from the date signed until written notification revoking the authorization has been received.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to our office. I understand that a revocation is not effective to the extent that Renaissance Reconstructive and Aesthetic Surgery, Inc. has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant tot his authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Renaissance Reconstructive & Aesthetic Surgery, Inc. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides great access rights)
- Refuse to sign this authorization
- Receive a signed copy of this authorization

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Date of Birth

_____
Description of Personal Representative

Matthew M. Akers, M.D. Melissa Berger, PA-C

Patient Name: _____ **DOB:** _____ **Age:** _____

Height: _____ ft. _____in. **Weight:** _____ **BP:** _____ **Pulse:** _____ **Resp:** _____

Reason for Today Visit: _____

Social History:

Alcohol: None **Type:** _____ **Amount:** _____

Tobacco: None Cigarettes: ____ pk/day for _____ years Tobacco/Cigars/VAP/E-Cigs Previous Smoker

Do you currently/previously use recreational and/or street drugs? _____

Exercise: None Sedentary Mild Exercise Regular Vigorous Exercise

Caffeine: Coffee _____ cups/day Soda _____ cups/day Tea _____ cups/day Other _____

Current Medications: None _____ List Provided to Office _____

Please list ALL Medications, Over the counter drugs, Herbal Supplements and Vitamins Below

Name: _____ Dose: _____ Name: _____ Dose: _____

Name: _____ Dose: _____ Name: _____ Dose: _____

Name: _____ Dose: _____ Name: _____ Dose: _____

Name: _____ Dose: _____ Name: _____ Dose: _____

Allergies:

List All Allergies/Reaction: _____ None Known: _____

Do you have an allergy/reaction to Latex, X-Ray Dye or Iodine? _____ None Known: _____

Do you have a History of Heart Valves/Artificial Joints: _____ Pacemaker: _____

Do you have History of MRSA: _____

Have you had recent Blood work, Chest X-Ray, EKG or mammogram? When? _____ Where? _____

If a biopsy or culture is obtained during your visit, it will be sent to an outside lab for evaluation. Please indicate which laboratory you prefer:

No Preference St. Rita's Medical Center Lima Memorial Hospital West Ohio Dermatology

*****Please note that all laboratory charges are billed separately from Dr. Matthew Akers charges *****

If you do not choose a Lab, it will be sent at the discretion of the Office

HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING: Please circle

General: Fever, chills, weight loss, weight gain, night sweats, numbness, fatigue, weakness

Eyes: Cataracts, double vision, glaucoma, loss of vision, glasses, contact lenses, dry eyes

Ears, Nose, Throat: Hearing Loss, Sinus infections, recurrent nose bleeds, difficulty swallowing, mouth/cold sores

Cardiovascular: High blood pressure, Heart disease, Heart Murmur, chest pain, palpitations, Heart Attack, High cholesterol

Respiratory: Cough, shortness of breath, coughing up blood, TB, asthma, COPD, wheezing, sleep apnea

Gastrointestinal: Difficulty swallowing, abdominal pain, bloody stool, constipation, nausea, diarrhea, heartburn, vomiting, reflux , hepatitis, jaundice, liver disease

Genitourinary: Kidney disease or failure, blood in urine, kidney stones, prostate trouble, sexually transmitted disease, homosexual activity, incontinence, currently/possibly pregnant

Musculoskeletal: Chronic joint or bone pain, swelling in ankles/joints, muscle pain, arthritis

Skin and Breast: Acne, rashes, new/changing skin lesions, itching, melanoma, skin cancer, breast lumps/pain

Neurologic: Headaches, seizures, dizziness, epilepsy, migraines, weakness or tingling arms/legs, Stroke, syncope

Psychiatric: Anxiety, depression, difficulty sleeping, bipolar, schizophrenia, PTSD

Endocrine: Diabetes Type I or Type II, thyroid disease, enlarged glands

Hematologic: Anemia, bleeding disorder, easy bruising, blood clots, Blood thinners: _____

Allergic/Immunologic: Lupus, HIV (AIDS), season allergies, recurrent infections

Cancer: List any type of previous/current cancer: _____

List any additional Health Issues: _____

History of Operations: None

Surgery: _____ Date: _____ Surgeon: _____

Surgery: _____ Date: _____ Surgeon: _____

Surgery: _____ Date: _____ Surgeon: _____

Surgery: _____ Date: _____ Surgeon: _____

Family History: None

Father: _____ Mother: _____

Brothers: _____ Sisters: _____

Grandparents: _____ Son/Daughter: _____

Patient Name: _____

Patient Signature: _____ **Date:** _____