

## Consent for Treatment, Financial Agreement, and Payment Policy

### PATIENT INFORMATION

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Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Patient email: \_\_\_\_\_ Previous Name: \_\_\_\_\_

*You may also decline to provide information on Race and Ethnicity.*

**Race:** \_\_\_\_\_ **Ethnicity:** *Please circle one:* Hispanic or non-Hispanic

### GENERAL CONSENT TO CARE

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- I am coming for care and treatment. I agree to services including examinations, procedures, lab services, tests and treatments, medication, monitoring, nursing care, counseling and education.
- I understand that electronic communication such as telemedicine may be used to help healthcare providers to participate in my care.
- I understand that some facilities participate in education and training programs and that I may receive healthcare services performed or observed by students/trainees. I understand that I can opt out of having a student/trainee during my visit.
- I understand that the provision of healthcare is not an exact science, and I acknowledge that no guarantees have been made to me as a result of examinations or treatments provided to me.

#### Important Information

- I know that I need to follow up with recommended care after I am discharged.
- I agree to notify St. Gianna Clinic within 1 hour if I am canceling or rescheduling an appointment.
- I know that the facility may take pictures or video of me for my care and safety.

#### Access to Healthcare Records

- I know that I may review my medical record during normal business hours upon reasonable notice.
- I know that I may get a copy of my medical record, and I may be asked to pay for the copies.
- I know that I may receive a \$5.00 fee if I request express delivery of my records. This fee will be collected before records can be sent.

#### Release of Information for Billing Purposes

- I agree that the facility and all healthcare providers participating in my treatment may release my health information to my insurers and other payers or other persons as necessary for billing, collection or payment of claims for services provided.

### ASSIGNMENT & FINANCIAL AGREEMENT

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- I assign to the facility or healthcare provider any payment for such services otherwise payable to me under a benefit Plan through Medicare, Medicaid, an insurance carrier(s), an employer health Plan(s) or any other third-party payer(s) (each referred to as "Plan").
- I allow my Plan(s) to send all payments directly to the billing facility or healthcare provider.
- St. Gianna Clinic will try obtaining any approvals and authorization required by my Plan if we receive the information in the appropriate amount of time to complete the authorization.

- I understand that should my Plan deny payment for the services provided to me, I am ultimately responsible for paying the charges billed for the services, including co-pays, co-insurance, and deductible charges consistent with any applicable, written contractual agreements between St. Gianna Clinic and my Plan. I agree to cooperate with St. Gianna Clinic of my payer's denials and authorize St. Gianna Clinic to be my representative on these appeals.
- I agree not to revoke this assignment and authorization without the facility's or healthcare provider's consent. If I receive payment directly from my Plan, it is my responsibility to forward it to St. Gianna Clinic within 30 days of receipt.
- I know that I am responsible for knowing the limitations of my Plan's benefit coverage. If my Plan determines that a service is not a covered benefit under the Plan or is experimental or investigational, I will be responsible for paying the charges billed by the facility or healthcare provider for the service(s).
- St Gianna Clinic reserves the right to balance the bill for any services in which a payment is made by a Non-Network Plan (i.e., there is no written contract between St. Gianna Clinic and patient's employer). I further acknowledge that, should the amount covered by my Plan(s) benefits be insufficient to cover the charges for the services rendered to me, I will be responsible for the payment of the difference.
- I agree that credit balances resulting from payments made by the patient or other sources may be applied to any account owed to the facility or healthcare provider by the same guarantor (me or my family).
- I understand St. Gianna Clinic offers a financial assistance program for patients who may not be able to pay for all of their medical expenses or need additional time to pay.

**Patient's Certification/Payment Request**

- Patient's Certification/Payment Request under Title XVIII and Tile XIX or the Social Security Act (Medicare/Medicaid):
  - I certify that the information given by me in applying for payment under Title XVIII and Title XIX of the Social Security Act and Wisconsin's Medicaid Assistance law is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim.
  - I request that payment of authorized benefits be made on my behalf.

**PRIVACY NOTICE AND PATIENT RIGHTS**

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- I confirm that I received or was offered and declined a copy of the Notice of Privacy Practices. There is also a copy posted in the waiting room. I know I can get more information about the uses of my medical record from that notice.
- I confirm that I will request a summary of the organization's financial assistance program if I feel it is necessary.
- I confirm that I received or was offered and declined a copy of the Patient Rights and Responsibilities. (There is also a copy posted in the waiting room.)
- I agree to let the facility or provider release information to other healthcare providers and school health offices through the Immunization Registry in the State of the facility or provider.

**Ethical & Religious Directives**

- I acknowledge that St. Gianna Clinic is a Catholic organization and provides all care in compliance with the Ethical and Religious Directives for Catholic Healthcare and that some services may not be provided at St. Gianna Clinic.

**Telephone Consumer Protection Act**

- I authorize all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me at any number I am providing or have previously provided orally or in writing, including my cell phone which could result in text/data charges to me and/or home phone or VoIP (Voice over Internet Provider) using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic email, text messaging or by any other form of electronic communication for any follow up purposes and to discuss any past, future, or current services, including billing and collection of any past due amounts.

**Consent to Use Replies and Reviews**

- I give St. Gianna Clinic permission to use my Google, Facebook or Instagram replies and/or review(s) including any text, rating, and/or name provided, for promotional/marketing purposes. I understand that this may include, but is

not limited to, sharing the review on the Clinic's website, social media platforms, printed materials, and other marketing channels.

- I acknowledge that my review may be edited for clarity or brevity, but its meaning will not be altered. I understand that no financial compensation will be provided for the use of my review.

**Disclosure to Third-Party Vendors**

- In the course of providing you with high-quality medical care, St. Gianna Clinic may engage third-party vendors and service providers to support various aspects of your treatment and healthcare operations. By signing this consent, you acknowledge and agree that your health information may be shared with these third parties, as permitted by law, for purposes such as care coordination, diagnostic services, laboratory testing, electronic health records management, and other services essential to your care. All such vendors are required to protect the privacy and security of your health information in accordance with HIPAA and applicable regulations.

**PAYMENT POLICY**

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Thank you for choosing St. Gianna Clinic for your health care. We are honored to care for you and your family and are committed to providing high-quality, compassionate, and affordable care. We understand that medical bills and insurance can sometimes be confusing or difficult to manage. Our goal is to make your financial responsibilities as clear as possible and to work with you when you have questions or are experiencing financial difficulty.

Please read this policy carefully and ask our staff if you have any questions. We are here to help.

**1. Insurance**

St. Gianna Clinic participates with many commercial insurance plans, as well as Medicare and Medicaid. Because insurance plans and networks can change, it is important that you confirm that St. Gianna Clinic and your specific physician or practitioner are participating providers with your plan. If we are not contracted with your insurance plan, payment in full may be expected at the time of service.

If you have Medicaid coverage through an HMO plan with which St. Gianna Clinic is not currently credentialed, you may need to select a new Medicaid HMO plan with which we participate in order to continue receiving non-emergency care at our clinic. We will work with you during a transition period of 30 days to give you an opportunity to change to a participating plan.

If we are unable to verify your active insurance coverage at the time of your visit, a \$150 payment will be required. This payment will be applied toward your visit once your insurance coverage is verified and the claim is processed, provided that St. Gianna Clinic is in network with your plan.

Understanding your insurance benefits is ultimately the patient's responsibility. Please contact your insurance company directly with questions regarding your coverage, benefits, deductibles, copayments, coinsurance, and network status.

**2. Out-of-Network and Non-Contracted Insurance Plans**

St. Gianna Clinic continues to work with insurance companies to expand the number of plans with which we participate in. However, we are not contracted with every insurance carrier or plan. If your insurance plan is out of network with St. Gianna Clinic, you may be responsible for amounts not covered by your insurance including deductibles, coinsurance, copayments, or balances resulting from your plan's out-of-network benefits.

If your insurance plan is in network with St. Gianna Clinic but the physician or practitioner you are seeing is out of network, it is your responsibility to verify the provider's network status before receiving services.

If we are not contracted with your insurance carrier, St. Gianna Clinic may not be required to accept the insurance company's payment terms. You may therefore be responsible for the cost of your visit, procedure, or other services.

Patients who choose to pay as self-pay may be eligible for a 25% self-pay discount on eligible visits and procedures through St. Gianna Clinic. Please speak with our staff for details.

### **3. Copayments, Deductibles, and Coinsurance**

Copayments, deductibles, and coinsurance amounts that are due at the time of service are expected to be paid at the time of your visit. These amounts are part of your insurance agreement and are your responsibility as the patient. Our clinic is required to follow applicable insurance contracts and laws regarding the collection of patient cost-sharing amounts.

If you are unable to pay the amount due at the time of service, please speak with our staff. We want to help you understand your options.

### **4. Secure Online Platform Messaging**

Patients may be charged for certain secure messages through our electronic health record patient portal, email, or other approved communication methods. If you message your physician or practitioner requesting medical advice, treatment recommendations, medication changes, or other services that require medical decision-making, the communication may be billed as a patient visit or other applicable service. Our staff will make reasonable efforts to help you understand when a charge may apply.

### **5. Blood Pressure Reading**

Patients may be charged for blood pressure readings that are self-measured or obtained outside of a scheduled office visit when the service is not part of an office visit, patient education, or training.

### **6. Self-Pay**

Patients who do not have insurance or who choose to receive services as self-pay are required to pay **\$150 at the time of service**. If you are unable to pay \$150 at the time of service, you will be asked to reschedule your appointment. The remaining balance for the appointment may be billed to the patient. Eligible self-pay services may receive a **25% self-pay discount** as described in this policy.

If you have an existing outstanding balance, you may be asked to pay the balance or establish an approved payment arrangement before continuing non-emergency care.

If you are experiencing financial hardship, please contact our billing specialist. We want to help you explore available payment arrangements or financial assistance options.

### **7. Non-covered services**

Please be aware that some services may not be covered by your insurance or may be determined by your insurance company or Medicare to be non-covered, not medically necessary, or otherwise excluded from your benefits.

You are responsible for charges associated with services that your insurance does not cover. When possible, we will provide information about services that may not be covered. However, insurance coverage is ultimately determined by your insurance plan.

## 8. Proof of insurance

All patients must provide current and accurate demographic and insurance information before receiving care. We require a copy of your driver's license or other appropriate identification and a current insurance card when applicable. If you arrive for an appointment without your current insurance card or are unable to provide valid insurance information, you may be required to **reschedule your appointment or pay the \$150 self-pay amount to be seen**.

If you pay \$150 because your insurance information could not be verified, the payment may be applied toward your visit after your insurance information is updated and the claim is processed, provided that St. Gianna Clinic participates with your insurance plan.

It is your responsibility to notify us promptly of any changes to your address, phone number, insurance coverage, or other information needed to process your claims. Failure to provide accurate and timely insurance information may result in you being responsible for the balance of a claim.

## 9. Claims submission

When applicable, St. Gianna Clinic will submit claims to your insurance company and will make reasonable efforts to assist you with the billing process. Your insurance company may request additional information directly from you. It is your responsibility to respond to requests from your insurance company in a timely manner.

Please remember that your insurance policy is a contract between you and your insurance company. St. Gianna Clinic is not a party to that contract. Any balance remaining after insurance has processed a claim is the patient's responsibility, regardless of whether the insurance company has paid the claim.

## 10. Coverage changes

Please notify St. Gianna Clinic of any changes to your insurance coverage before your next appointment whenever possible. Providing updated insurance information helps us submit claims correctly and helps you receive the benefits available under your plan. If an insurance company does not process or pay a claim within **45 days**, the outstanding balance may be billed to the patient while the claim is being resolved.

## 11. Past-Due Balances

We understand that circumstances can arise that make it difficult to pay a medical bill. If your account becomes past due, we encourage you to contact our billing specialist as soon as possible. If your account remains more than 90 days past due, you may receive written notification requesting that the balance be paid or that an acceptable payment arrangement be established within 30 days.

We will make reasonable efforts to work with patients who communicate with us and are willing to address their balance. If a balance remains unpaid and satisfactory arrangements have not been made, the account may be referred to a collection agency. In some circumstances, continued non-emergency care may no longer be possible. If dismissal from the practice becomes necessary, you will be notified in writing and given an appropriate period of time to establish care with another provider, consistent with applicable requirements. During any transition period, our ability to provide care may be limited to emergency services.

## 12. Missed Appointments and Late Cancellations

We understand that unexpected circumstances happen. To help us provide timely care to all our patients, we ask that you notify us as soon as possible if you are unable to keep your appointment. A **\$25** fee will be charged for the first appointment that is missed or canceled with less than 1-hour notice. A **\$50** fee will be charged for the

second appointment missed or canceled with less than 1-hour notice. A **\$100** fee will be charged for a third appointment missed or cancelled with less than 1-hour notice and will result in dismissal from the practice.

Missed appointment fees are not typically covered by insurance and are the patient's responsibility. Please help us to serve you better by keeping your regularly scheduled appointment.

### **13. Patient Balances**

We understand that medical expenses can sometimes become a financial burden. Our goal is to work with you, not against you, when a balance becomes difficult to manage. If you have an outstanding balance, we may be able to assist you through one of the following options:

- Payment plan: We may be able to establish a payment arrangement that allows you to pay your balance over time.
- Financial assistance: You may apply for financial assistance if you meet the clinic's eligibility requirements.
- Pay-in-full discount: You may be eligible for a discount when your balance is paid in full. Please ask our billing staff whether a discount is available for your account.

A pay-in-full discount and a payment plan cannot be combined. You may choose the option that works best for your situation, when eligible.

### **14. Financial Assistance Applications**

We encourage patients who are experiencing financial hardship to ask about our financial assistance program. We are happy to provide an application and help you understand the process. Once a financial assistance application is provided to you, you have one month to complete and return the application and any required documentation. For example, if an application is provided on September 1, it must be returned by October 1. If the application is not returned within the required timeframe, you may need to request a new application and begin the process again.

Financial assistance approvals are generally valid for six months. Financial assistance does not automatically renew. It is the patient's responsibility to remember to request and complete a new application when the current approval period ends. If you are having difficulty completing an application or gathering the requested information, please contact our billing staff. We will do our best to help you through the process.

### **15. Working Together on Your Balance**

We recognize that every patient's financial circumstances are different, and we want to make a reasonable effort to work with you when you have an outstanding balance. At the same time, maintaining an active payment arrangement or participating in the financial assistance process requires cooperation from both the patient and the clinic. Patients are expected to communicate with us, provide requested information, make agreed-upon payments, and follow through with the option they have selected.

If we have made reasonable attempts to work with you and you are unwilling to communicate, participate in available assistance options, or make arrangements to address your balance, continued care at St. Gianna Clinic may no longer be possible. Our hope is always to work together to find a solution that allows you to continue receiving care.

**GUARANTOR/RESPONSIBLE PARTY** *(This is for the person responsible for the bill, if not the patient.)*

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Subscriber: \_\_\_\_\_ DOB of Subscriber: \_\_\_\_\_  
 Insurance Name: \_\_\_\_\_ Patient's Insurance ID: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?** *(Please mark all that apply.)*

- ☐ Web Search ☐ Radio ☐ Facebook ☐ Ad in *On Mission*  
☐ Patient/Friend ☐ Parish Flyer ☐ Fox 11  
☐ Billboard ☐ Creighton Model Fertility Care Practitioner or NFP Instructor  
☐ Other: \_\_\_\_\_ ☐ Physician: \_\_\_\_\_

\_\_\_\_\_ Please sign if you grant St. Gianna Clinic authority to download your medication history from your pharmacy. *(This will allow us to gather your medication history if your pharmacy sends the information.)*

\_\_\_\_\_ Please sign if you grant St. Gianna Clinic authority to share and receive your medical information with your other healthcare providers. *(This will allow us to gather your medical history electronically.)*

**Document Changes**

- I know that if I refuse to sign this form, or make any changes to this form, prior to non-emergent services performed, it may keep me from getting care and services.

**DOCUMENT ACKNOWLEDGEMENT AND DURATION**

- My signature indicates that I have read and understand the **Consent to Treatment, Financial Agreement, Privacy and Practice Notices** and **Payment Policy**.
- I understand that this agreement applies to all St. Gianna Clinic facilities and is valid for one year for treatment.
- St. Gianna Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

**I have read and understand these policies and agree to abide by their guidelines:**

\_\_\_\_\_  
**Signature of patient or responsible party**

\_\_\_\_\_  
**Date**