FINANCIAL POLICY for Scott McDowall M.D

Thank you for choosing us as your health care provider. We are committed to your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our ***Financial Policy***, which we require you to read and sign prior to any treatment:

1. All patients must complete our information and insurance form before seeing the doctor.
2. For your convenience we accept cash, check, Visa, MasterCard, American Express and Discover.

We have contracts with most commonly used insurance companies. Please check to see if we accept your insurance. If we do not accept your insurance policy, as a courtesy, we will bill your company. Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. If we bill your insurance company and they have not paid your account in full within 45 days, the balance may be automatically transferred to your credit card or billed directly to you. Any subsequent visits must be paid in full at the time the services are rendered. Please be aware that some insurance companies, including Medicare, may determine treatment to be non-covered or find it not to be reasonable or necessary. If such a determination is made, you will be responsible for such services. Such services will be billed, and payment is due upon receipt of bill.

Regarding insurance plans where we are a participating provider: All co-pays and deductibles are due at the time of treatment. If there are any additional procedures performed, they may be subject to an additional **Co-Payment, Deductible or Co-Insurance.** Please refer to your HealthCare Plan for additional information. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

Usual and customary rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what constitutes a usual and customary rate.

Minor patients: The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, Discover or payment by cash or check at the time of service has been verified.

Missed appointment: Unless canceled at least 24 hours in advance, you may be subject to $25.00 no-show fee at the physician's discretion. Please help us serve you by keeping scheduled appointments.

Co-pays and Balances: Co-pays are due at the time of service. If we need to bill you for the co-pay, there will be an additional $5.00 processing fee. You will also be asked to pay any outstanding patient balance.

Insufficient Fund Fee: Checks that are returned will be charged a $45.00 insufficient funds fee.

Collection Fee: Unpaid balances may be turned over to an outside collection agency. In the event your account is turned over for collections, you as the patient will be responsible for all fees and costs associated with collecting the balance.

Thank you for understanding our ***Financial Policy***. Please let us know if you have any questions or concerns.

I have read the *Financial Policy* and I understand and agree to its provisions.

_____ Date_____

Signature of patient or responsible party

Authorization of Use and Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____ SSN: _____

I. My Authorization

You, Scott McDowall M.D may use or disclose the following health care information:

- ☐ **ALL** my health information maintained by you.
- ☐ My health information relating to the following treatment or condition: _____
- ☐ My health information for the date(s): _____
- ☐ Other: _____

You may disclose this health information to:

Name (or title) and organization: _____
Relationship: (parent, child, sibling, legal guardian, etc,): _____

Name (or title) and organization: _____
Relationship: (parent, child, sibling, legal guardian, etc,): _____

Name (or title) and organization: _____
Relationship: (parent, child, sibling, legal guardian, etc,): _____

This Authorization ends: ☐ on (date) _____
☐ When the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to receive treatment. However, I may be required to sign this authorization form:

- To take part in a research study; or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization at any time, in writing, sent to Dr. Scott McDowall at the address provided below. If I do, it will not affect any actions already taken by Dr. Scott McDowall based upon this authorization; uses and disclosures already made cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance.

- 100 Whetstone Place Suite 206, St Augustine, FL 32086

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized signature Date

Patient is unable to sign because of (minor, disabled, etc.) _____