ADELANTE HEALTHCARE

ANNUAL CONSENT & ACCEPTANCE OF FINANCIAL RESPONSIBILITY

AA12.FIN.FRM

PATIENT INFORMATION	
PATIENT NAME:	DATE OF BIRTH:
FAMILY SIZE _______ (how many in the household) ESTIMATED INCOME _________ ☐ Monthly ☐ Annually	HEAD OF HOUSEHOLD ________________________ DATE OF BIRTH ________________________________

PERSON RESPONSIBLE FOR CHARGES IF OTHER THAN PATIENT	
NAME:	EMPLOYER:
ADDRESS:	HOME PHONE:
CITY, STATE, ZIP:	WORK PHONE:
DATE OF BIRTH:	CELL PHONE:

THE INITIAL DEPOSIT DOES NOT REFLECT THE TOTAL COST OF THE OFFICE VISIT

Medical Self-Pay patients including OBGYN Services

Office visits range from $80 to $250 depending on the consult, visit type, and complexity of care received by a provider or member of the care team. A deposit is required prior to services being rendered:

New patients that are self-pay: $100.00 DEPOSIT required at time of check-in.

Established patients that are self-pay: $80.00 DEPOSIT required at time of check-in.

I understand the deposit amounts listed above does not reflect the total cost of the visit and will be billed separately for any remaining balance owed. **Please initial here:** __________

Dental, Registered Dietitians, Behavioral Health patients, and OBGYN services

Integrated Care specialties such as Integrated Behavioral Health, Dental, Registered Dietitians and OB may require different or additional office visit copays and/or deposits may apply based on insurance coverage.

If your total visit amount is determined to be higher than the deposit received, we will collect the balance at the end of your visit or bill you for the difference. If your office visit is determined to be lower than that of the deposit amount collected at the visit and no additional charges are incurred (such as labs and in-office procedures), we will issue a refund for the difference back to the patient or guarantor listed on the account.
If special supplies are used during your visit, your provider will discuss any additional costs (items may include IUD's or pessaries).

All copays and coinsurance charges are due at the time of service.
Additional copays and/or charges may be due in the event that the patient sees multiple members of the extended care team or additional providers from different specialties on the same date of service (For example, Behavioral Health, Dietician, Hygienist, Dentist, or PCP on the same day). If you schedule a wellness visit that

may be covered by your insurance for no copay or fee, and a medical issue is addressed during this visit, a copay and/or charges may be due as it will be a separately billable service. Additional services may vary by individual insurance coverage levels.

By signing below, you acknowledge that you fully understand.

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all health services provided by Adelante Healthcare regardless of whether I have insurance or not. I understand that while Adelante Healthcare contracts with many insurance companies, it is my responsibility to verify with my plan that Adelante Healthcare is a participating provider. It is my responsibility to know what is or is not a covered service. It is also my responsibility to find out what my coverage options are with my insurance plan. I further understand that I authorize Adelante Healthcare to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that Adelante Healthcare uses an external collection agency in order to collect on any past due accounts. If my bill is not paid in full after 90 days from the date of service my account may be turned over to this agency.

Adelante Healthcare reserves the right to charge a fee for overdue accounts and returned checks.

I hereby consent to authorize all examinations including virtual consults, physical exams, x-ray, Behavioral Health, Registered Dietitians, and laboratory procedures, which may be necessary in the judgement of the provider for diagnostic purposes. As a teaching institution, there may be students and/or trainees involved in my care, I understand that I have the right to refuse their services at any time.

I authorize Adelante Healthcare staff to take photographs; I understand that these photographs will be used as a record of my care and for identification purposes. If used, any identifying information will be kept confidential. I understand that I will not receive any form of compensation for these photographs.

____
PATIENT/GUARDIAN NAME

____
PATIENT/GUARDIAN SIGNATURE

____
DATE