Patient Financial Responsibility Form
and HIPAA Consent Form

1. Individual Financial Responsibility: I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered service. Co-payments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at the time of service. I understand that it is my responsibility to know my insurance benefits, coverage, exclusions and any pre-authorization requirements. If there is no payment or attempt for payment, after 3 statements, I understand my account will be sent to collections. If my account is sent to collections, I understand the entire balance must be paid in full before I can return to Stellar Healthcare. If my account is sent to collections a second time, I understand that Stellar Healthcare will terminate the healthcare relationship and that I must find other health care.

2. Insurance Authorization for Assignment of Benefits: I hereby authorize Payers to direct payment of my medical benefits to Stellar Healthcare and my attending health care provider on my behalf for any services furnished to me. "Payers" are any health care insurance, private or government health plan or insurance policy that I have or another third party that will pay the charges I have incurred. My signature on this form is my authorized signature for the filing of a claim and request for direct payment of benefits by any Payer to Stellar Healthcare and my attending health care provider. I agree that unless Stellar Healthcare or my attending health care provider have agreed with the Payer to accept payment from the Payer as full payment, I am responsible for paying any charge not paid by the Payer. These charges may include but are not limited to co-pays, deductibles, co-insurance amounts and charges for non-covered services.

3. Authorization to Release Records: I hereby authorize Stellar Healthcare and my attending health care provider to release necessary health information to any Payers. This information may include but is not limited to records of any diagnosis, treatment, or examination needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to other medical providers.

4. HIPAA Consent: I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I understand that by signing this form I consent and authorize Stellar Healthcare to use and disclose my protected health information for the purposes of: treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); obtaining payment from third party payers (e.g. my insurance company); and carrying on the day-to-day healthcare operations of its practice.

I have also been informed of my right to secure and review a copy of Stellar Healthcare's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that Stellar Healthcare reserves the right to change the terms of this notice from time to time and that I may contact Stellar Healthcare at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions be placed on the use/disclosure of my protected health information for any out treatment, payment, or health care operations. However, I acknowledge

that Stellar Healthcare is not required to agree to these requested restrictions. Nonetheless, if Stellar Healthcare does agree to said restrictions, it is then bound to comply with them. Stellar Healthcare may not condition treatment, payment, enrollment or eligibility for benefits on whether I agree to the HIPAA consent. I understand that I may revoke this HIPAA consent, in writing and upon delivery, at any time. However, any use or disclosure that occurs prior to the date of revocation of this consent is not affected. My revocation does not impact the other terms of this form.

5. Medicare Request for Payment: If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made on my behalf to Stellar Healthcare and my attending health care provider for any services furnished to me by Stellar Healthcare and my attending health care provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information· needed to determine these benefits or benefits for related services.

6. Acknowledgment: By signing below, I agree to be contacted by Stellar Healthcare, its affiliates, and/or a company hired by them using automatic dialing systems, recorded or artificial voice messages, text messages, emails, and/or similar methods. The purpose for these messages may include appointment reminders or other health care messages, patient feedback, surveys, marketing or promotional messages, unpaid balance messages, and/or other business messages. If unable to reach me, I authorize (**check all that apply**):

- ☐ **the leaving of a detailed voice message;**
- ☐ **the leaving of a detailed text message; or**
- ☐ **the leaving of a generic message asking to return the call.**

Patient needs to check above before signing

I have read the information above and my signature below serves as acknowledgment of a clear understanding of my financial responsibility. If I am not the patient with whom this form concerns, I represent that I am authorized by law to agree to these conditions on the patient's behalf and am the authorized representative of the patient. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full. A copy of this form is as effective and valid as the original.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Printed Name Relationship to Patient if no patient signature