GRACE HEALTH CLINIC
Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Grace Health Clinic appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period (90 days), you will be responsible for your balance in full.

Grace Health Clinic prides itself in providing care to patients with varying financial circumstances and insurance carriers. For this reason, patients who are covered under certain government plans, including Medicaid and Medicare, will be required to join Grace Health Clinic's Membership, specific to the coverage plan which the patient is insured. Please refer to "Pricing and Membership Plans." Patients who have elected to join a Membership Plan will need to be current on payments **PRIOR** to having services rendered with Grace Health Clinic. Any patient who is delinquent on payments will be required to pay existing balance prior to rendering of services. If a patient is not current with membership payments and would like to have a medical visit with GHC, the patient will be required to submit a payment equal to those of non-members (please see "Private/Self Payers" section on "Pricing and Membership Plans" form at the time of their visit.

I understand that my payments for Grace Health Care Membership plans is a fee to the clinic and do not represent direct payment for care obtained with Grace Health Clinic. Any cost of care which exceeds 30% of the amount that the patient pays for a membership, in 1 year, will be charged to the patient or the patient's insurance. The membership plan prices are subject to change.

I have read the above policy regarding my financial responsibility to Grace Health Clinic, for providing medical services to the above-named patient or me. I have also read the "Clinic Pricing and Membership Plans" form. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Grace Health Clinic, the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ Date _____

Consent for Treatment and Authorization to Release Information

I hereby authorize Grace Health Clinic, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures. I further authorize Grace Health Clinic, to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

Patient Name: _____ DOB: _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

The Practice will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

Self-Pay
(Please complete if applicable)

I do not have health insurance and will be responsible for services rendered here at Grace Health Clinic. I agree to pay Grace Health Clinic, the full and entire amount of treatment given to me or to the above-named patient at each visit.

Patient/Guarantor Signature _____ Date _____

Motor Vehicle Insurance (PIP)
(Please complete if applicable)

I do not have health insurance. I request my claims be submitted to my motor vehicle carrier. I understand I will be responsible for bills incurred by me in the event my PIP benefit exhausts or denies.

Patient/Guarantor Signature _____ Date _____

Patient Name: _____ DOB: _____

Grace Health Clinic Members

___I have elected to become a member of Grace Health Clinic and have chosen to pay a monthly membership fee. I understand that any services provided through Grace Health Clinic are contingent upon a payment status, which is current, and that any balance is due prior to medical evaluation.

___I decline membership to Grace Health Clinic Membership

Patient/Guarantor Signature _____ Date _____

Please complete below, if you have elected to become a member.
(Please check the one that applies):

___ Tier 1: $39.95 monthly fee (1 face-to-face visit plus 1 eVisit encounter per year)
___ Tier 2: $59.95 monthly fee (2 face-to-face visits plus 1 eVisit encounters per year)
___ Tier 3: $79.95 monthly fee (3 face-to-face visits plus 2 eVisit encounters per year)
___ Tier 4: $99.95 monthly fee (4 face-to-face visits plus 2 eVisit encounters per year)
___ Tier 5: $119.95 monthly fee (5 face-to-face visits plus 3 eVisit encounters per year)
___ Medicaid Membership: $20.00 monthly fee

____Exclusive Membership/Concierge Service: $359.95 monthly fee- unlimited face-to-face visits plus unlimited eVisits. 3 home visit allowances, yearly (M.D. to make home-visits).

Credit Card Payment(s)

Name (as it appears on card): _____

Card Number: _____

Exp. Date: _____ Recurring payment amount (see Tier above): _____

Signature: _____ Date: _____

For recurring charges, including membership fees, a credit card is **REQUIRED. Initial charge will be deducted immediately and the monthly fee will be charged to the provided credit/debit card on the 15th day of each month, continuing the month after initiation of the plan.*

Billing Rights Summary

Our acceptance of any payment marked with a restrictive legend or otherwise marked "pain in full" will not operate as an accord and satisfaction without our express prior written approval. If you believe this statement is incorrect, or if you need additional information, contact us in writing or by phone. When you contact us, please provide your name and account number. Describe the error or problem. Please pay in U.S. Dollars. Checks should be written from a U.S Bank. If a check is written from a foreign banc, add $35.00 for U.S. Bank processing fees or pay by an American Express Money order. Grace Health Clinic will charge a procession fee (added to the balance due on your account) for any check which is returned by the back "Non-Sufficient Funds"/"NSF". This fee will cover the expense incurred by Grace Health Clinic for Bank Fees, extra processing to correct the account balance and additional statement procession. We are required by federal and state law to maintain the privacy of your health information. Therefore, if you contact us regarding statements, we will ask you to provide certain information to identify yourself. Please notify us is you want another person to act as your representative regarding your account. Your representative will also be asked to provided specific identifying information related to you. We will only discuss information regarding your account that is directly relevant to your account, e.g., providing the account balance, taking insurance information and setting up budget plans. We will not discuss any heath information related to diagnosis or medical treatment with any caller, including you.

Revised 9/2018

Patient Name: _____ DOB: _____

Grace Health Clinic
Emergency Contact Form

Please list 2 emergency contacts below.

Emergency Contact 1:

Name (first/last)

Address City State Parish/County

( ) -

Phone Number

Emergency Contact 2:

Name (first/last)

Address City State Parish/County

( ) -

Phone Number

Revised 9/2018