Ballantyne Diagnostic & Sleep Center
11220 Elm Lane, Suite 102, Charlotte, NC 28277

FINANCIAL POLICY

PATIENT NAME: _____ DATE: _____

Thank you for choosing Ballantyne Diagnostic & Sleep Center (BDSC) as your health care provider. It is the policy of this practice to provide the finest quality of medical care available. In an effort to make our services available to as many patients as possible on an affordable basis, this practice employs firm practice management. This enables us to provide the highest level of care, and at the same time be sensitive to cost containment. In an effort to be fair to all patients, we have adopted the financial policy outlined below. **Please take the time to read this policy in its entirety:**

1. PAYMENT IS DUE AT TIME OF SERVICE
2. MOST MAJOR INSURANCE PLANS ARE ACCEPTED AND FILED AS A COURTESY TO OUR PATIENTS.
3. WE ACCEPT CASH, CHECKS, VISA and MASTERCARD.

Returned (NSF) checks will be charged back to the patient's account with an additional service fee of $30.00. At the discretion of management, returned checks may be resubmitted to your bank a second time. Returned checks not redeemed within 20 working days of written notice to the maker may be subject to prosecution.

REGARDING INSURANCE

Your insurance identification card is required at the time of each service. Insurance verification, if performed, is not a guarantee of coverage or payment. Ultimately, your insurance policy/employee benefits plan is your responsibility, and we encourage patients to be aware of their own plan and its allowable services. Additionally, we encourage patients to follow up with their insurance companies to inquire upon knowledge of any unpaid services. If you are uncertain to what items are covered or what you will be responsible for, please contact your insurance company representative for assistance. This phone number will be on your insurance card.

To help reduce paperwork and relieve patients of financial burdens, we have entered into contractual agreements with most insurance and third parties. Patients covered under these programs will be responsible only for the services covered, deductibles and participations in accordance with their specific contracts.

_____ *Initials* If your insurance company/employee benefits plan has not paid for a service within 45 days of being filed, the balance will become your responsibility. At that time, you will be billed for any unpaid services and payment from you is due in full. If your insurance pays after you have paid, you will be reimbursed within 30 days.

_____ *Initials* Co-payments, co-insurance and deductibles are due on the day services are rendered.

NO SHOW/LATE CANCELLATIONS

_____ *Initials* There is no charge for appointments that are rescheduled or cancelled at least 24 hours PRIOR to the scheduled time. Appointments that are NOT rescheduled or cancelled at least 24 hours prior to the scheduled time will be charged a $200.00 missed appointment fee except in the case of Medicare.

I have read the foregoing request and authorization in its entirety and agree to be bound by all terms and conditions herein.

_____	_____	_____	
Patient Signature	**Date**	**Name of Parent or Legal Guardian**	**Signature**	**Date**

MEDICARE INSURANCE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Carolina Family Healthcare. I authorize any holder of medical information about me to release the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

Patient Signature: _____ Date: _____

HIPAA PRIVACY NOTICE

I have been provided a copy of BDSC Notice of Privacy Practices.

_____	_____	_____
Patient Signature (or Authorized Representative)	**Date**	**Relationship to Patient**

Reason Patient Unable/Unwilling to Sign: _____

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FINANCIAL POLICY

PATIENT NAME: _____ DATE: _____

ASSIGNMENT OF PROCEEDS, LIEN AND AUTHORIZATION

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or legal entities, which may elect or be obligated to pay, provide or distribute benefits to me for any medical conditions, accidents, injuries or illnesses, past, present or future to pay directly and exclusively to Ballantyne Diagnostic & Sleep Center (BDSC) such sums as may be owing to BDSC for charges incurred by me at the office relating to my condition, with such payments to be made exclusively in the name of BDSC. I further grant a lien to BDSC with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document, "benefits" shall include, but not limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, medical payments, third-party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

I authorize BDSC to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this agreement and lien. I further authorize and direct all payers to release to BDSC any information regarding any coverage or benefits which I may have including, but not limited to the amount of coverage, the amount paid thus far and the amount of any outstanding claims. I hereby direct this office to file a copy of this assignment and lien together with any said payers. I hereby grant BDSC power of attorney to endorse/sign my name on any and all checks listing me as a payee which are presented to BDSC for payment of an account relating to me, my spouse or any of my dependents. I further authorize BDSC to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of these other charges related to my condition.

I understand that I remain personally responsible for the total amounts due to BDSC for their services. This assignment and lien does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take any action to collect outstanding balance on my account, I will be responsible for payment and will reimburse BDSC for all costs of such collection efforts, including but not limited to all court costs and all attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of BDSC and myself. I hereby revoke any previously signed authorizations, whether executed at this or any other office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

Patient Signature: _____ Date: _____

Name of Custodial Parent or Legal Guardian (please print): _____

Parent/Legal Guardian Signature: _____

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read the foregoing and understand it.

Patient Signature: _____ Date: _____