Steinmetz Medical Associates, P.C.

FINANCIAL AGREEMENT

(Please initial after each paragraph to indicate that you have read each paragraph and sign at the bottom).

I, ________________________________, agree to be responsible for the costs of medical care provided by Steinmetz Medical Associates, P.C. (SMA) for myself or my dependent, ________________________________. If I default on my obligation and SMA refers my account to an attorney for collection, I agree to pay all collection costs, including collection agency fees and attorney costs. I also authorized SMA to release the medical reports of the above patient to any attorney retained by SMA to collect any amount due on my account. I also agree that I will pay interest on any unpaid balance at the rate of one percent per month. A billing charge of $7.00 may be added to your account. x________

I understand SMA is <u>not</u> a participating provider with any insurance. I authorize automatic submission of any claim. I further authorize the release of any information needed for processing my insurance claims; there could be a charge for this service. A copy of this authorization may be used in place of an original. I understand and agree I am financially responsible for uncovered services, deductibles and co-pays by my insurance company. Blue Cross Blue Shield/CareFirst does not send SMA any insurance payments or explanation of benefits; payments are sent directly to patients. As a result of this, BCBS/CareFirst patients are required to pay at the time of service. x________

I understand that laboratory testing will be done through Steinmetz Medical Associates P.C. x________

I understand my insurance may not cover charges for services provided. This may include but not be limited to phone calls, e-mails, after hour calls, consultations with professionals regarding your case, medical record review, copying of medical records/reports, pre-authorizations, prescription refills ($20.00), outside lab interpretations ($100.00), shipping & handling of products ($20.00) and researching difficult cases. x________

I am responsible to pay for appointments not cancelled 24 hours prior to my appointment time. This covers the cost of office overhead during this time. Cost will be based on time scheduled for appointments at a rate of $250.00 per hour. There is a $50.00 charge for returned checks. I understand there are no exceptions to these charges. x________

The Virginia Medical Practice Act requires physicians selling dietary supplements, but not any other store or professional, to give the following notice. These dietary supplement products are being recommended for improvement of your overall health and to help meet nutritional needs. Steinmetz Medical Associates has a financial interest in the sale of this/these product(s). It is not necessary for you to purchase the product(s) from SMA. You may purchase the same or similar products at a retail pharmacy, health food store, through mail order or other sources. I have read the above and will be given an invoice with the name and prices of purchased products. x________

I understand no reimbursement is available from Medicare. Physicians at SMA have opted-out of the Medicare program. x________

I understand physicians at SMA are not certified with the Tricare network. SMA fees for services are above the 115% limit for the Tricare fee schedule. x________

I acknowledge that I have received and/or read a copy of the Notice of Privacy Practices from Steinmetz Medical Associates, P.C. *(on the back of this page)* x________

Signature x____ Date ________________

Updated: 03/12/2010