Arkansas Family Care Network

Financial Policy and Consent Form

Welcome to our clinic! We are committed to providing you with the best care possible. Please read this information carefully.

Financial Information

If you have health insurance coverage, we will file claims on your behalf. Please make sure that you provide current, accurate insurance and policyholder information at each visit. By providing this information to us, you authorize any services furnished to you by our providers to be paid directly to Arkansas Family Care Network, P.A. ("AFCN"). If your health insurance plan requires co-payment, the co-payment is due at the time of service. You are responsible for paying for any services not covered by your insurance, and any deductible or co-insurance is your responsibility. Prior balances are due at the time of service unless prior payment arrangements have been authorized. Please help us by paying your co-payment on each visit.

If you do not have health insurance, you must pay in full at the time of service or make arrangement for payment prior to your scheduled appointment. We accept cash, personal checks, MasterCard, Visa, Discover Card, and American Express.

It is necessary for you to know what benefits your health insurance plan provides for you. Not all services provided are covered by every plan. You should determine whether prescribed testing (lab, radiology, etc.) is covered by your insurance. Additionally, many insurance plans require you to use certain hospitals or doctors and may require pre-certification or referrals to a certain hospital. We are not responsible if you are sent to a hospital that is not covered by your insurance. It is your responsibility to know which doctor or hospital your plan requires you to use.
AFCN will send you a monthly statement for services provided. Payment is due upon receipt of the monthly billing statement. Even if you have insurance, prompt payment of your statement balance is your responsibility.
Accounts not paid in full within 30 days are considered past due. If you cannot make regular payments, please contact us. We may refer your outstanding balance to a collection agency. Any fees incurred in the collection of your outstanding balance will be charged to you.

If your medical care is the result of a work-related injury, your claim will be sent to your employer. They may pay directly or forward to workers compensation carrier for payment. If the carrier information is available to us, we will bill the carrier directly. It is your responsibility to complete any necessary forms to allow us to release information to your employer or the workers' compensation carrier.

If your medical care is the result of a motor vehicle accident or other third-party liability accident, you will need to let us know at the time of service if the insurance claim should be sent to your private health insurance or if the claim needs to be sent to another insurance carrier. We will bill the liability carrier and allow 30 days for payment. You will be responsible for payment on any claims pending litigation or settlement. In the event a work comp, motor vehicle, or third- party liability bill is returned to us as unidentifiable or denied or the claim is pending litigation or settlement, we reserve the right to bill your medical insurance.

Consents

If you would like someone else to have access to your protected health information, please list any people authorized to receive your health information with relationship and phone number. By providing this information you give consent to allow the following person(s) access to information on my account that would otherwise be considered Protected Health Information.

Name:	Relationship:	Phone Number:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

Assignments of Benefits

I understand and agree that payment of authorized benefits under my insurance carrier(s) will be made to me or on my behalf to the provider for any services or supplies provided by AFCN. I authorize the release of any medical or other information necessary to process an insurance claim on my behalf.

Consent to Treat

I voluntarily consent to care and treatment deemed necessary by the providers at AFCN. My consent includes, but is not limited to medical examinations, diagnostic testing, surgical procedures, ultrasounds, laboratory testing, and vaccinations.

Pharmacy Health Information Exchange

I consent that AFCN may obtain my medication history information electronically through a pharmacy health information exchange. AFCN accesses this information to know what medications I am taking so that they can treat me appropriately and avoid adverse drug reactions.

Telemedicine

I consent to participate in any telemedicine/virtual visit that I request or initiate with an AFCN provider.

Communication Consent

I understand and agree that AFCN may contact me using automated calls, emails, and text messaging to my mobile device. These communications may notify me of preventive care, test results, treatment recommendations, outstanding balances, or any other communications from AFCN. If I chose not to receive any or all communications, I must inform the clinic.

By signing, I acknowledge that I have read and understand the policies contained in this document and agree to comply. I further give my consent for the activities described in this document.

_____ _____

Signature of Patient or Legal Guardian Date