ASSISTED LIVING FINANCIAL POLICY

Lykos Medical

Today's Date_____

Patient Name_____
Last First MI

Date of Birth _____SSN _____

We are committed to providing you with the best possible medical care. If you have medical insurance, we would like to help you receive the maximum allowable benefits. In order to achieve this goal, we will need your assistance and understanding of our financial policies. Please carefully review this information and sign/initial where indicated.

***** *Any changes to personal information must be given to the office immediately*****

ASSIGNMENT: I request that payment of authorized insurance, Medicare, and Medicaid benefits be made payable to Lykos Medical LLC on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office.

_____ ***(Initial) I have read and agree to the above statement.***

CO-PAY/COINSURANCE/DEDUCTIBLE: I understand that my primary insurance will be billed; billing secondary insurance is a courtesy only and I am ultimately responsible for assigned co-payments, coinsurance and deductible amounts by primary and/or secondary insurance. Tertiary insurance billing remains my responsibility.

_____ ***(Initial) I have read and agree to the above statement.***

RELEASE OF INFORMATION: I authorize the holder of medical information about me to release any and all information to Centers for Medicare and Medicaid Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize Lykos Medical LLC to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.

_____ ***(Initial) I have read and agree to the above statement.***

REQUESTS FOR INFORMATION: Should I receive any requests from my insurance company in regards to my services at this office, I must respond to that correspondence immediately, in order to have the claim processed and paid.

_____ ***(Initial) I have read and agree to the above statement.***

PAYMENTS: Self-pay and previous balance amounts are due when billed. Insurance co-payments are mandated by your insurance company and will be billed **after** each visit. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided. If I have questions, I understand to contact the office first.

_____ ***(Initial) I have read and agree to the above statement.***

RETURNED CHECKS: I understand and agree to pay a returned check charge of $35.00 for each check that is returned for any reason. I agree to pay the amount of the check plus the service charge within 30 days of receipt of notification.

_____ ***(Initial) I have read and agree to the above statement.***

PRIVACY POLICY: I have been made aware of the privacy policy of Lykos Medical LLC and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

_____ **(Initial) I have read and agree to the above statement.**

I have read and agree to the above information and I, the undersigned (patient or POA), am ultimately responsible for the fees. By signing below, I consent to be contacted by regular mail, by email or by telephone (including a cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages.

PRINT NAME_____

SIGNATURE _____ DATE _____