Patient Request for Medical Services & Financial Responsibility Statement

Welcome to Mid-Atlantic Kidney Centers. We are committed to being a part of your healthcare team. We have listed a few things about your financial responsibilities to our practice.

This notice is to advise you that your health plan may or may not cover the health care services provided by this medical practice. The reasons that health plans deny coverage can include, but are not limited to: 1) the services are not medically necessary or are experimental/investigational as defined by your plan, 2) the party financially responsible for benefit payment does not pay within a contractual or regulatory time period, is insolvent, or does not provide reasonable written explanation for delayed payment, 3) the health plan determines you are not eligible for benefits, 4) the health plan's utilization management or authorization program has not pre-approved services, or 5) the services are excluded or are not Covered Services under your plan of benefits.

Our practice participates with the majority of health plans and will continue to do so with plans that offer acceptable contractual terms. Our practice makes every reasonable effort to verify your eligibility and benefits prior to services being rendered and to adhere to the utilization management and pre-authorization programs that may be applicable. However, even when plans verify such information they reserve the right to later deny coverage. In the event that your plan denies coverage of services that you and your physician deem appropriate, you will be responsible for payment of services.

In the event that coverage is denied and you have opted to have services performed, at your request, *MKC* will provide you with a description of services and the estimated charges. In some circumstances, a payment plan may be arranged. Please contact Christina Mason if you would like information on the services, associated charges and payment terms.

I, _____(print patient name), understand the information provided above and that I may request a description of services and an estimate of the amount that will be charged. I agree to be responsible for payment of billed charges related to services for which my health plan has denied payment. I understand that sometimes additional services may be necessary after initial services are provided due generally to findings of initial services. I agree to make payments within 30 days of the date of a billing statement unless other arrangements have been agreed upon in writing in advance. If I do not make timely payment, I further agree to be responsible for interest charges and costs related to the collection of such amounts including collection fees and court costs.

_____

Patient Signature Date

_____

Print Name of Person Responsible (if not patient) Signature Date