Financial Policy Agreement

Thank you for choosing **Lung and Sleep Disorder Center**, a division of **Centric Health,** a multi-specialty group practice, as your healthcare provider. We are committed to providing you with superior and quality healthcare. We appreciate your commitment to adhere to this Financial Policy Agreement.

Patient with Medical Insurance Benefits:

It is your responsibility to provide our office with a picture I.D., and valid insurance coverage information. You must notify us of any changes in your insurance coverage immediately. Many insurance companies have timely filing limits, if you provide us with insurance information after those limits have expired, you will be responsible for those services.

We are participating most major health plans. We have contracts with many PPO's, HMO'S, insurance companies as well as government agencies including Medicare. Our business office will submit claims for any services rendered, and assist you in any way reasonable to help get your claims paid. Your insurance may delay and/or deny claim payment pending requested information from the subscriber of your plan; it is your responsibility to comply with their request. Any such delays or denials will be your financial responsibility.

Copay's, Co-insurances, and Deductibles:

All copays, Co-insurances, deductibles, and current balances are due prior to services being rendered. If such payments are not made at the time of services, our business office will send you a statement for your balance. It can be difficult at times to offer an exact quote of your portion due, we can however offer an estimation upon request. Under no circumstances is an estimation considered final payment or payment in full. Balances on claims are not considered final until after your insurance has processed the complete claim.

Non-covered and Out-of-Network services:

Medical services considered by your insurance company to be non-covered, out-of-network, or not medically necessary will be your responsibility. Our office will attempt to verify benefits for services provided, but it is ultimately your responsibility to know your coverage.

Patient's WITHOUT Medical Insurance Benefits:

We recognize that some of our patients may be without insurance coverage or choose to receive care from our Providers even when we are not considered "participating providers" with their health plan. We offer reasonable determine the best way to handle your account.

Other Policies and Service Charges:

Payment Plan:

If at any time you are having a difficulty paying your account, we encourage you to contact our business office at (661) 31-2796, to set up a reasonable payment plan. We have many options to help during your financial hardship.

Balance Policy:

Our business office will send statements regularly; if you have any questions or dispute your balance, it is your responsibility to contact our business office within 30 days. Any past due accounts may be referred to an outside collection agency and subject to interest and negative rating with varies credit bureaus.

_____Patient Initials

Waiver of Patient Responsibility:

It is our policy to treat all patient's ins a fair manner related to account balances. We will not waive, fail to collect, or discount any co-pays, co-insurance, deductible, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with our Financial Hardship policy. Please contact our business office at (661) 371-2796 for more information.

Form Completion Policy:

All forms requiring medical review and physician signature are subject to an administrative fee of 25.00 per form. This fee will be due prior to release of any completed forms.

Request for Medical Records:

We require written request for all releases of medical records. Request for records are subject to an administrative fee of 25.00 per request plus 0.25per page copied. We reserve the right NOT to release any records until such fees are paid.

Return Check Policy:

Any check returned from the bank as unpaid, is subject to a return check fee of $25.00 per check payable by cash, money order, or credit card. We may choose to refuse future check payments on your account. In addition, we may seek all additional legal remedies provided to us under California law, including but limited to reporting your returned check to the local District Attorney's office.

Missed Appointment:

We understand there may be times you might have to miss an appointment due to other obligations or emergencies. We require at least 24-hour notice of any appointment's cancellations. If a 24-hour notice is not provided it is at the discretion of the office to charge a $25.00 missed appointment fee. Cancelling your appointment in advanced gives us an opportunity to offer medical services to another patient.

By signing this agreement:

*I acknowledge I have read and understand Centric Health's Financial Policy. A copy will be provided to me upon request.

*I understand I am financially responsible for any services not paid by my insurance company.

*I authorize and direct Centric Health to release all information needed, including medical records, to substantiate any claim or payment to any governmental agencies, insurance carriers, or others who are financially liable for payment of medical services provided to me.

* I authorize payment for medical services to be paid directly to Centric Health.

*I understand this agreement will remain in effect until I have formally revoked in writing.

*I understand Centric Health's financial policy may be amended without prior notice.

Patient Name: _____ Date:_____

Patient or Legal Guardian Signature: _____

Relationship to patient, if not other than self: _____

Lung and Sleep Disorder Center, Inc

Dear Patient,

The Physician of Lung and Sleep Disorder Center are now a division of Centric Health, multi-specialty medical group. As part of this change, we have a new computer system and need some additional information from you. We appreciate your cooperation and patience during our transition. Please provide us with the following information, Thank you.

Primary Doctor: _____ **Referring Physician:** _____

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Phone:** _____ **Cell:** _____

Work: _____ **Race:** _____ **Preferred Language:** _____

Would you like to enroll in our online portal? **Email:** _____

Pharmacy: Local: _____ **Mail Order:** _____

Authorization to Discuss Medical Information

Authorization to discuss medical, information with spouse and other relatives and caregivers:

I, _____, Hereby authorize discussion of my medical information with:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient / Responsible Party Signature : _____ Date : _____

Lung and Sleep Disorder Center, Inc/ Muhammad Ashraf Alim MD, FCCP,FAASM,

3008 Sillect Ave Bakersfield CA 93308/ Phone: 661-377-0091 Fax: 661-377-1715

Medical Release Request

Physicians Name: _____

Street Address: _____City: _____ State: __ Zip: _____

The following individual has asked us to request that his/her medical records be released and forwarded to our office:

Patient Name: _____ DOB: _____

Address: _____ City: _____State: ___ Zip: _____

Medical Records _____ Radiology _____ Lab _____ Others _____

Thank you for expediting this request. Please send these records to our office.
I hereby authorize the release of all necessary medical records to **Dr. M Ashraf- Alim.** I wish for them to be forwarded as soon as possible.

Patient Signature: _____ Date: _____

Signature of Witness: _____ Expiration Date: _____

Muhammad Ashraf Alim M.D., F.C.C.P, FAASM

3008 Sillect Ave Suite #140 Bakersfield Ca 93308

(661) 377-0091 Phone (661) 377-1715

Prescription History Consent

I, _____, authorize Muhammad Ashraf Alim M.D., to both access and use my electronic prescription history. I understand in doing so I am allowing Muhammad Ashraf Alim M.D., to access a full electronic history of prescriptions that have been prescribed to me by any/all of my healthcare providers including but not limited to hospitals, urgent cares, dentist and private practice physicians. I am also allowing Muhammad Ashraf Alim M.D. to access records in regards to prescriptions filled in my name by local, mail order and specialty pharmacies.

This authorization shall expire on_____. (Failure to specify an expiration date will result in this authorization expiring in 12 months.)

_____ _____

Patient/Responsible Party Signature Date