Fiat Family Medicine

Robert Pranger, MD
Katie Weigel, FNP-BC
Elizabeth Myhr, FNP-BC
220 Southbrooke Dr.
Waterloo, IA 50702
Phone: 319-236-7751
Fax: 319-236-7753

FINANCIAL RESPONSIBILITY AND RELEASE FORM

FINANCIAL RESPONSIBILITY

Charges for services provided by Fiat Family Medicine ("FFM") cover the following components: services provided by physicians and staff, all supplies and medications used during your appointment; and any lab tests performed at FFM. We request payment of your copay or deductible amount, if applicable, on the date of service. If you are unable to pay this amount in full on the day of procedure, you may be asked to sign a promissory note detailing the payment amount and due date of the remaining balance.

We will submit a claim to your insurance carrier after receiving complete billing information and within 90 days of your visit. If there is no insurance information provided, you will be responsible for the full amount of the charges for the services provided. If any additional funds are owed after insurance has processed the claim, you will be notified via electronic and mailed statements. In the event that any such amount is placed with our collection agency, you will be responsible for the collection fees, reasonable attorneys' fees, and court costs.

We file your insurance claim for you as a courtesy to you, however, our relationship is with you, not your insurance company. It is your responsibility to be knowledgeable regarding your insurance coverage and benefits. We will expect your assistance in obtaining payment from your insurance company if difficulties arise. After 90 days, with certain exceptions, the balance will become payable in full by you.

Fees for physician services, procedural assistants, Anesthesiologist/Anesthetists, pathologists, laboratory work performed outside FFM are separate from FFM's fee and your responsibility for payment for these fees is between you and that provider of the service.

SPLIT BILLING NOTIFICATION

Our office would like to make patients aware of any split billing charges before they are included on the claim, but this is not always a possibility. Insurance often covers a yearly physical at no cost to the patient, but that only includes your general screenings for potential health issues. If there are other problems that need to be addressed while the patient is at FFM for their yearly physical, there may be an additional “office visit” charge to address those other concerns rather than requiring the patient to come back for a separate appointment to address those concerns. Office staff is not required to inform you of this potential charge, but this reminder is posted in the patient rooms as a courtesy. You may ask about whether a visit will be split-billed, and you may request an

itemized statement at any time to review the charges submitted to your insurance. This is best done by submitted a request by phone, text or email.

SELF-PAY POLICY

For patients who are under-insured or are working with a Health Share company for their medical care, we offer a 25% discount of charges for all self-pay appointments. To qualify for the self-pay discount, you are expected to pay at the time of service unless other arrangements have been agreed upon with the physician or office staff. To request a quote for services, contact office staff by call, text, or email.

NO SHOW POLICY

Patients who do not show up to appointments without prior notification may be subject to a $45.00 scheduling fee. We require scheduled appointments be canceled or rescheduled at a minimum of one hour prior the the scheduled appointment time. Any patient who fails to provide notification of a cancellation or reschedule by 5:00PM the day of the appointment will be charged a $45 scheduling fee. This fee must be paid before scheduling future appointments. Fee can be paid by cash, check or card, in person or over the phone.

After 3 missed appointments, the patient will be subject to a review by office staff. At this review, office staff may determine to terminate services and the patient will be dismissed from the practice. The patient will be provided with written notice of this action and will have 30 days to find a new provider before services are terminated.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment to Fiat Family Medicine for any medical and/or procedural insurance benefits otherwise payable to me or on my behalf for the procedure(s) performed at FFM, at a rate not to exceed FFM's regular charges.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize FFM and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number etc.) for the purpose of helping me to resolve claims, to determine liability for payment, to obtain reimbursement, and to resolve health benefit coverage issues. This includes, but is not limited to, insurance companies, health care service plans, and auto insurance or worker's compensation carriers.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to FFM. However, this authorization may not be revoked if, it’s employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

STATEMENT OF UNDERSTANDING

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

I HAVE READ AND UNDERSTAND THE MEANING AND TERMS OF THE ABOVE PARAGRAPHS. I ACCEPT ON BEHALF OF MYSELF AND/OR THIS PATIENT ALL OF THE ITEMS LISTED IN THESE PARAGRAPHS EXCEPT AS CROSSED OFF AND INITIALED. A photocopy of this authorization shall be considered as valid as the original.

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____
Print Name

_____ _____
Patient's or Guardian's Signature Date