**South County Sleep Disorders Medical Center**
2520 Samaritan Drive, Suite 104A • San Jose, CA 95124
18511 Mission View Drive, Suite 160A • Morgan Hill, CA 95037
*Phone:* (408) 356-8900 • *Fax:* (855) 834-6677

# Financial Policies

**PATIENT'S NAME:** _____

**PRIVACY PRACTICES:** I have read and understand the Privacy Practices posted in our office. If I would like a copy, I can request one from the office.

**PAYMENT AGREEMENT:** I agree to pay for all Medical Services provided by *South County Sleep Disorders Medical Center*, Harish H.K. Murthy, M.D., and any other physician acting on his behalf.

**INSURANCE AGREEMENT:** I understand that as a courtesy, BASS Medical Group Billing Services will file an insurance claim(s) for any services provided. It will be expected that payment will be prompt from my insurance company (usually within **30 days** of the billing date). If this is not the case, I will assist in collecting from my Insurance Carrier or settle my bill within the 30-day billing period. I agree that unpaid insurance balances are my ***full responsibility***. I also understand that if my insurance claim(s) is placed on hold for any reason, I am fully responsible for paying my balance within the 30-day billing period.

**INSURANCE:** We are currently contracted with Medicare and most PPO insurance. **We are NOT contracted with Covered California, Medi-Cal, Stanford Healthcare Alliance (SHCA), Select PPO Plans, Pathway PPO/EPO, UC Select, UC Care, Core, EPO's, and some HMO's**. If Medi-Cal is my secondary insurance, I understand that I am responsible for unpaid balances. SCCIPA , TRICARE, and any other accepted HMO patients **must obtain an authorization from their PCP** prior to the appointment. If I am not sure what my policy rates are, I understand that it is my responsibility to contact my insurance company. I will expect to receive a bill within 30 days of the insurance Explanation of Benefits (EOB).

**SELF PAY:** If I do not have insurance, or have an insurance that is not accepted, I will be billed at 110% of the current Medicare rates for Santa Clara County. To receive the most current costs, I may contact BASS Medical Group Billing Services.

**PAYMENT PLANS:** If I am unable to make payments in full, I understand that I may call BASS Medical Group Billing Services to arrange a payment plan.

**AUTHORIZATION AND RELEASE AGREEMENT:** I hereby authorize the release of any medical information necessary to process these claims, and I request payment of insurance benefits to: *BASS Medical Group*. I also authorize the release of any information acquired in the course of my examination or treatment to the hospital, other physicians, and/or my insurance company.

**REFERRAL AGREEMENT:** If required by my insurance, I agree to provide a referral or request from my **Primary Care Physician (PCP)** and/or **Referring Physician** at the time of my visit.

**BROKEN-APPOINTMENTS AGREEMENT:** I agree to notify *South County Sleep Disorders Medical Center* within **48 hours** if I am unable to keep my appointment. If notice is not given within 48 hours, a charge of **$100.00** may be posted to my account. I agree to pay this amount in the event of a late cancellation or no-show, and I am aware that no appointments may be made until such fees are cleared.

**NSF-CHECK RETURN AGREEMENT:** I agree to pay the **$25.00** Non-Sufficient Fund charge, should my check not clear.

**CHANGE OF ADDRESS AND/OR INSURANCE AGREEMENT:** I agree to notify *South County Sleep Disorders Medical Center* of any changes to my address, phone number, employment, and/or insurance.

I have read all the above information on this sheet and have agreed that, regardless of my insurance, I am ultimately responsible for the balance of my account for any services and/or charges rendered.

| _____ | _____ | _____ |
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| Signature of Responsible Party | Print Name if other than patient | Date |

BASS MEDICAL GROUP