

STATEMENT AND ACKNOWLEDGEMENT OF FINANCIAL POLICY

Mowery Clinic is a participant in many insurance plans and will be listed in your group's provider list if we are participating in your plan. We will bill your insurance directly and in most cases receive payment directly from them. However, to avoid any confusion, please be aware that we do expect payment for applicable deductibles, co-payments or co-insurance amounts and for known non-covered services at or prior to the time of your services.

If your insurance requires prior authorization for any of your treatment and if this authorization has not been obtained before your visit, you will be expected to pay for all charges incurred. If your insurance subsequently authorizes those services, your payment will be refunded upon receipt of insurance payment.

If you do not have insurance, payment is expected at the time of service. We accept Visa, Mastercard and Discover for your convenience. If payment in full is not possible at the time of services, payment arrangements will need to be made in our Accounts Management Department prior to your appointment.

If you need forms completed such as for disability or the Department of Motor Vehicles, there will be a minimum fee of \$20 per form. If you are unable to keep a scheduled appointment, kindly provide the physician's office 24 hours of advance notice. Please note that we reserve the right to charge for appointments that are not kept or cancelled in advance.

Statements are mailed monthly to patients with an outstanding balance. If you are unable to pay your balance within 30 days, please contact our Accounts Management Department at one of the numbers below to make payment arrangements. Interest at 10% per annum is assessed on all patient responsibility balances after 60 days. Patients who fail to comply with this payment policy or in meeting the terms of their arranged payment plan may have their accounts turned to an outside collection agency and be terminated from receiving further medical care from the practice.

The Accounts Management Department is available from 8:00 A.M. to 5:00 P.M., Monday through Thursday, and from 8:00 A.M. to 12:00 Noon on Friday. We may also be reached by phone at (785) 822-0260 or (785) 822-0272. If these lines are busy and you reach our voice mail, please leave a detailed message and we will return your call as soon as possible. Our voice mail is also available to you after hours for your convenience.

Thank you for choosing Mowery Clinic.

I have read and understand Mowery Clinic's payment policy.

PRINT PATIENT NAME: _____

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

**ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received a copy of Mowery Clinic's Notice of Privacy Practices with the effective date of October 1, 2014.

Signature of Patient/Personal Representative

Date

Relationship to Patient

Patient's Name

For Mowery Clinic Use Only

The above named Patient/Personal Representative was provided with a copy of Mowery Clinic's Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgment of his/her receipt of the Notice, but such acknowledgment could not be obtained because:

___ Patient/Personal Representative refused to sign.

___ Patient/Personal Representative was unable to sign.

___ The Patient had a medical emergency and an attempt to obtain the acknowledgment will be made at the next available opportunity.

___ Other reason (please specify): _____

Signature of Workforce Member Completing Form:

Date

Original to be maintained in Patient's medical record

**MOWERY CLINIC
AUTHORIZATION FOR USE OF
PROTECTED HEALTH INFORMATION**

Printed Name of Patient _____ Patient's Date of Birth _____ Patient's Social Security # _____

Printed Name of Person Submitting Request (if other than Patient) _____ Relationship to Patient _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Mowery Clinic, L.L.C., its physicians and/or staff to share verbally or otherwise diagnostic reports, other medical information, and all relevant portions of medical record information about me or the above named patient for whom I possess parental custody or other legal authority to:

_____	_____	_____	Yes No
First and Last Name	Relationship to Patient	Phone Number	Allow Messages?

_____	_____	_____	Yes No
First and Last Name	Relationship to Patient	Phone Number	Allow Messages?

_____	_____	_____	Yes No
First and Last Name	Relationship to Patient	Phone Number	Allow Messages?

_____	_____	_____	Yes No
First and Last Name	Relationship to Patient	Phone Number	Allow Messages?

_____	_____	_____	Yes No
First and Last Name	Relationship to Patient	Phone Number	Allow Messages?

NOTE: No verbal or phone message(s) will be left with any individual other than yourself or those persons listed above.

ALTERNATE COMMUNICATIONS:

I hereby authorize Mowery Clinic, L.L.C., to contact me via the following methods of communication with regard to my Protected Health Information (PHI) or the PHI of the above named patient (this includes, but is not limited to, appointments, test results, etc.).

NOTE: Please indicate the preferred order of contact for each of the alternate communication items listed below (i.e. indicate "1" for FIRST preference, "2" for SECOND preference, "3" for THIRD preference, etc.).

_____	May messages be left at this number?	Yes	No
Pref # Home Phone Number			

_____	May messages be left at this number?	Yes	No
Pref # Day Phone Number			

_____	May messages be left at this number?	Yes	No
Pref # Cell Phone Number			

_____	May messages be left at this number?	Yes	No
Pref # Alternate Phone Number			

_____	May messages be left at this email address?	Yes	No
Pref # Email Address			

_____	May messages be left at this point of contact?	Yes	No
Pref # Other (please include description)			

I understand that this authorization will be in effect for the duration of treatment and follow up unless terminated by me in writing.

Patient Signature or Patient Representative Signature

Date