



Annual Patient Consent for Release of Information and Medical Claims Processing

By signing below, I (the patient) understand that I will be held financially responsible for all charges resulting from services provided. I authorize direct payment of medical benefits from my insurance company to Pioneer Physicians Network, Inc. In addition, I authorize release of any medical information necessary for reprocessing of these claims for payment including, but not limited to, facsimile transmission of information.

I consent to the use of my medical information necessary for transmission of prescriptions to the pharmacy and as needed for the coordination of formulary and/or benefits eligibility with my insurance provider. I consent to the query of my external prescription history as necessary to manage my healthcare and related services.

In accordance with the notices of privacy practices, I authorize the use and disclosure of any medical information with a third party to coordinate or manage my healthcare or any related services.

- Co-pays, deductibles and/or co-insurance are to be paid when you arrive at check-in. In accordance with your health insurance policy, your co-pay or other time of service responsibility payment is to be paid in full at the time of your office visit. We accept cash, personal checks, Visa, MasterCard, Discover and American Express. You may also use your HSA or debit card. \*Please note that if you use your HSA card – refunds can only be returned to the HSA card and cannot be directly refunded to the patient or to the patient account.
If you are covered by a High Deductible Health Plan (HDHP): Health Reimbursement Account (HRA) and Health Savings Account (HSA), you will be required to pay a fee of \$150 at the time of service if you have not met your deductible. Your required payment may be adjusted based on the level of services to be provided.
If you do not have health insurance, payment must be made at the time of service. A driver’s license or other identification will be required for all self pay accounts. Note: until insurance eligibility is verified, your account will remain as “self pay” and you will be required to make payment at the time of service.
Self Pay Time of Service Discount: If your financial status is “self pay” you are expected to pay in full at the time of service. For payment in full at the time of service, you will receive a 20% discount on all office based services and a 40% discount on all laboratory services.
Worker’s Compensation (BWC) claims require special processing. You will be required to complete BWC claims processing information at the time of service. If information is not provided, your account will remain as self pay. Not all Pioneer Physicians are BWC providers. Please contact your office location and inquire. They will direct you to the proper location. This also includes ODOT physicals.
Motor Vehicle Accident (MVA) will be considered self pay and will require payment at the time of service as well as completion of a patient consent form. Pioneer Physicians will provide necessary information to you regarding your MVA claims however, will not process claims to your health or auto insurance carrier.
We will ask you for payment on your outstanding balance when you arrive for your visit unless payment arrangement has previously been made. If you are unaware that you have an outstanding balance, it may be because we do not mail billing statements if your account balance is less than \$4.99. Our office staff would be happy to provide you an itemized statement at your request.
Your balance is due in full upon receipt of your monthly statement. This includes co-insurance, deductibles, and services not covered by your insurance policy and services billed to your insurance company but were denied for payment after repeated attempts by our billing department to resolve the disputed claim. You are responsible for working with your health insurance company should they request additional information from you for your claims to be paid.
Returned checks: For each NSF check, our fee is \$45.00. If we receive an NSF check, we will not accept another personal check from you until the NSF fees are paid and a payment for the returned check has been made. If we receive two (2) returned checks on an account, we will no longer accept personal checks.
Failure to make your payment in full, or as arranged, may result in your account being turned over to a collection agency. If your account is sent to collection, it may appear on your credit report. Your healthcare services relationship with Pioneer Physicians Network and your physician may be impacted as our policy is to dismiss patients that have been sent to collections and their household members from all physicians and ongoing services of the practices.
Refund Checks: Patient/Guarantor credits in amounts less than \$20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts \$20.00 and greater will be automatically refunded to the patient/guarantor. Refunds are processed within 30 days.
We will work with you in every possible way to resolve any discrepancies with your account and/or to make acceptable payment arrangements when you contact us for assistance. If you have any questions and/or feel you are not receiving the service you should, please contact our billing department at 330-899-9350. Pioneer Physicians Network billing services are provided by our revenue cycle department located in our administration office in Uniontown, Ohio.
A “no-show” appointment patient is a patient who has failed to report for a scheduled appointment without previous notification of cancellation. Missed appointments are disruptive to the provider and do not allow for the scheduling of other patients that are waiting to be seen, Please give 24 hours notice if you need to cancel a scheduled appointment, so that we will be able to utilize that time slot for a patient in need of an appointment. You will be given a courtesy call before your appointment to remind you of your appointment. If you fail to show for an appointment you may be sent a letter warning you of a possible \$25.00 fee and/or dismissal from our practice.

I have read and understand the Pioneer Physicians Network Financial and Annual Patient Consent for Release of Information and Medical Claims Processing Policy. I agree to assign insurance benefits to Pioneer Physicians Network whenever necessary.

Patient Name (printed): \_\_\_\_\_

Patient Signature (or authorized representative): \_\_\_\_\_

Date: \_\_\_\_\_