

Financial Agreement & Advanced Beneficiary Notice

Maestro Healthcare enjoys offering extended visits, combining services such as psychotherapy and psychopharmacology to improve outcomes as well as offer a more efficient model of care. In order to do this, it is important to understand we need to collect payments in a timely manner for services offered as well as fees that have been applied to your account. The guarantor listed on file will be the party legally and financially responsible for the account. This is usually the patient, but can be a parent, guardian, or another entity such as an employer. In the case of the treatment of a minor, only one parent will be listed as we cannot split responsibility.

We accept most major credit cards, checks, or cash. We ask that a credit card be kept on file and up to date. We will process payment on the card for services rendered or to provide payment for charges to your account for balances due. We will only charge your card for services provided or fees discussed in this agreement.

For all missed appointments or late cancellations, we will charge the card on file generally by the end of the respective day or within 24 hours of the visit, however this is not guaranteed and can be at a later time.



Assignment of Benefits

The assignment of benefits authorizes the practice to file the insurance claim, accept payment from the insurance carrier, and collect patient balances directly from the patient and/or guarantor. The Medicare lifetime beneficiary claim authorization gives the provider permission to file claims on behalf of a patient to Medicare.

For those health care providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those health care providers who have rendered services to me and who accept such assignment.

Information about me that is necessary to substantiate my insurance claims may be released by the health care provider involved in my care.



Financial Responsibility

I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to the health care providers are not paid after reasonable notice, that account shall be deemed delinquent and a service charge might be added to the amount due. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default.

In the event of missed or late cancel appointment, there will be a fee. A late cancel is considered less than 24 hours in advance. Please understand it is your responsibility to notify our office and you must receive confirmation of our receipt of your communication.



Medicare Lifetime Beneficiary Claim Authorization

I request that payment of authorized medical benefits be made either to me or on my behalf to Maestro Healthcare, LLC for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agent any information needed to determine benefits or the benefits payable for related services.

I understand my signature requests that payment be made and I authorize release of medical information necessary to pay the claim. If other health insurance is indicated on item

9 of the CMS-1500 claim form or elsewhere on the approved claim form or electronically submitted claim, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept that charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.



Notice of Non-Coverage

We have reason to believe your insurance company may not pay for the "Items/Services" listed below rendered by Carencia because of certain coverage problems that will be listed under "Reason." You can still receive this care, since you or your healthcare provider may have good reason to think you need it, but it is likely you will have to pay. We have estimated about how much you may have to pay under "Estimated Cost" to help you decide whether or not to receive the care listed.

Items/Services	Reason	Estimated Cost
Venipuncture	Not in our contract	\$25
Urine Drug Screen Cup*	Not in our contract	\$15
Missed/Late Cancel Visit 30 minute	Not in our contract	\$75
Missed/Late Cancel Visit 60 minute	Not in our contract	\$120
FMLA/STD (per completion)	Not in our contract	\$60
Social Security/Formal Disability	Not in our contract	\$225
After Hours Visit**	Not in our contract	\$30
Prolonged Healthcare Service	Not in our contract	\$140
Telephone Consultation	Not in our contract	\$20
Vivitrol Care/Case Management	Not in our contract	\$15

If we are not in-network with your insurance carrier, you will be responsible for the full-service fee. We will provide you with a receipt you may submit for possible reimbursement at your request, however we do not attempt billing for non-contracted insurance carriers at this time. For your convenience, the services fees are listed below.

* The fee associated with the urine drug screen cup is for the cost of procurement and is not regarding the technical/clinical services of evaluating/analyzing the results of the specimen sample.

** After hours visits are considered out of the normal operating hours set forth in our agreement with insurance contracts. The qualifying times and days for this designation are visits after 5:00pm CST and before 8:30am CST. The days this covers are Saturday and Sunday of every week and all nationally recognized holidays. This fee is a voluntary fee for those that prefer to have visits after customary hours for their own convenience or needs and is by no means an obligation to attend visits during these times.



Fee Schedule

Our rates, fees, and financial policies are all subject to change at any time. Please know it is your responsibility to check the website for the most up to date costs and fees schedule.

* After hours call are calls are outside of M-F 9-5 hours and that are not related to a recent visit and this is determined by a 48 hours window after the most recent office visit or 24 hours before the next visit.

Service	Fee
New Patient Evaluation	\$225
Follow Up Visit Therapy	\$225
Follow Up Visit for Medicine	\$125
Missed/Late Cancel Visit	\$120 Initial/Therapy \$75 Medication/Follow Up
Venipuncture	\$25
Urine Drug Screen Cup	\$15
FMLA/STD (per completion)	\$60
Secondary Claim Filing (Time/Admin)	\$20
After Hours Visit	\$30
Phone Consultation /After Hour Calls	\$20
Vivitrol Care/Case Management	\$15/month
Medical Records Request	\$25 for for 20 pages. + \$0.25 for each additional page. + \$10 processing fee. + any postage costs.



Credit Card Authorization

I, _____, authorize Carencia to charge my credit card for agreed upon purchases and fees for service. I understand that my information will be saved to file for future transactions on my account.

Credit Card Information

Card Type: MasterCard Visa Discover AMEX Other:

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

CVV: _____

Card holder Zip Code (from credit card billing address): _____

Our rates, fees, and policies are all subject to change at any time. By signing this agreement, as the patient/guarantor, you understand and agree to abide by our financial agreement which includes authorization to charge the card on file for services rendered or fees accrued. I understand that my information will be saved on file for future transactions on my account.

Patient Name (Printed): _____

Patient DOB: _____

Guarantor (If not patient): _____

Patient/Guarantor Signature: _____

Date: _____