FINANCIAL AGREEMENT FOR PAYMENT OF SERVICES

Thank you for choosing us as your healthcare provider. The following is our financial policy. If you have any questions or concerns about our payment policies, please contact our office staff at info@apnshealth.com.

1. APNS is a cash pay practice. We only accept payments via debit or credit card. Only a debit or credit card can be used for payment.
2. Your insurance policy is a contract between *you*, your employer, and the insurance company. Our relationship is with you, not your insurance company. All services are provided to you with the understanding that you are responsible for their cost, regardless of your insurance coverage. If you would like, to know the cost of a service, please inquire with the staff prior to purchase or treatment. Please be aware that not all services are a covered benefit in all insurance policies. *You* are responsible for knowing, per your insurance plan, what services are and are not covered. Fees for these services, along with any unpaid deductible and co-payment are due *prior* to the time of treatment. You are responsible for these amounts.
3. *You* are responsible for knowing your insurance benefits. Some examples are, but not limited to, the following: Does your insurance require a referral? What facilities participate in your plan? We do not know, nor are responsible for knowing, the policy details of your individual plan. Again, that is between you, your employer, and your insurance company.
4. If there is any balance, we will send you a statement monthly, to keep you informed of the status of your account until the account is paid in full or placed into collection.
5. If you are a Medicare or Medicaid beneficiary, by federal law, we are prohibited from collecting a cash payment. Failure to disclose to the practice or your provider that you have Medicare, Medicaid, or other federal or state sponsored health insurance may be interpreted as intent to fraud these government programs. APNS reserves the right to take any and all actions necessary to protect itself from liability arising from a patient's misleading, deceptive, incomplete, or fraudulent statements, omissions, or failure to disclose material information.
6. Prior to making any payment, the patient is provided access to all applicable policies, disclosures, consent forms, financial agreements, and other relevant documentation for review. The patient acknowledges that he or she has been afforded a reasonable and adequate opportunity to read, review, ask questions regarding, and seek independent advice concerning such documents before making payment and receiving services.
7. By submitting payment and receiving services, the patient knowingly, voluntarily, and irrevocably agrees to be bound by all applicable policies, procedures, disclosures, and consent forms of APNS. The patient further acknowledges that failure to read, review, understand, or inquire about any policy, disclosure, consent, agreement, or procedure shall not serve as a basis for cancellation, rescission, chargeback, reimbursement, refund, dispute of charges, or any claim against APNS. To the fullest extent permitted by applicable law, the patient expressly waives any right to seek a refund, reimbursement, offset, or chargeback for services rendered, reserved, scheduled, or made available by APNS.
8. By signing this payment agreement, I acknowledge that I have personally guaranteed the debts and obligations incurred to me by APNS and agree that I am personally obligated to perform all the terms of and make all payments to APNS required by the agreement of which this new patient packet is a part. I authorize the office of APNS to release any necessary financial information to third parties when requested. If I become delinquent in my payment(s), I acknowledge that my account will be assigned over to a collection agency, and that they are hereby given the right to report the same account delinquency accurately to any and all Credit Bureaus. I agree to pay all collection expenses APNS may incur in collection of any delinquent balance, plus attorney's fees, court costs, filing fees, and charges or commissions that may be assessed by any collections agency retained to pursue this matter. Collection fees may be 40% for regular collections, and

50% for legal collections or forwards, which may be as much as twice the original principal balance owed. I further agree to pay an interest rate of 5% (five percent) per month, 60% (sixty percent) per year from the first date the account becomes delinquent.

By electronically signing this document you agree to the following:

(a) Subject to applicable law and the terms and conditions of any applicable contract between APNS and a third party payer, and in consideration of all health care services rendered or about to be rendered to the patient, you will be financially responsible and obligated to pay APNS for any balance charged for services rendered or attempted to be rendered by APNS.
   i. I understand that attempted services indicates that APNS has engaged either through asynchronous, synchronous on demand, or scheduled synchronous visits and circumstances or occurrences stated in the APNS Patient Behavior Policy, to which I have agreed to and electronically signed may result in services attempted not being completed or fulfilled. If services are attempted, that alone fulfills the obligation by APNS and requires my payment in full to be fulfilled.

(b) Subject to applicable law, and in consideration of all health care services rendered or about to be rendered, you agree to be financially responsible and obligated to pay APNS for the patient balances due.

(c) Consent to Contact. You authorize the APNS and all APNS providers who have provided care to the patient, along with any billing services, collection agencies or other agents who may work on their behalf, to make contact on the cell and/or other phone number provided using automated telephone dialing systems, text messaging systems, electronic mail , or other computer assisted technology to provide messages (including prerecorded or text messages) about the patient's account, payment due dates, missed payments, information for or related to medical goods, supplies, prescriptions, equipment, and/or services provided, and other health care information.

(d) You promise to update the patient portal within 30 days if the patient phone number(s), email(s), address(es) or other demographic information necessary for communication with the patient change and understand that the APNS will continue to use the communication information provided unless a notice of change is made by the patient or responsible party.

(e) You give permission for the APNS to communicate information to you via electronic mail and/or SMS texting and understand that such information may not be encrypted or secure. To the extent allowed by law, APNS will not be liable to you for any calls or electronic communications, even if information is communicated to an unintended recipient.

(f) To provide optimal compensation to out providers and staff, the patient is responsible for attending any appointment or responding to the provider within a reasonable time frame, but no more than 3 days. Providers are entitled to a fair and predictable wage, and "No Showing" to an appointment does not mean that provider should not be compensated for his/her time. Therefore, you agree by signing this financial agreement that you forfeit your payment for services to APNS regardless of whether you attend your visit.
   i. If, and at the discretion of the APNS, the patient has had more than three "no shows" within a twelve-month period, the patient may be subject to dismissal and APNS reserves the right to discharge the patient from care.

(g) Acknowledgements Receipt of Notice of Privacy Practices. You have received or have been offered a copy of the Notice of Privacy Practices which describes how the patient's health information may be used or disclosed by the APNS. It is understood that this Notice is provided the first time the patient receives services and then only when a significant change is made. Otherwise, it is available by request or on the APNS's website. Electronic Communication. You may also receive emails and text messages from us that will include updates on our APNS, general health news, and business updates. You can unsubscribe at any time using the link included on all emails. California Consumer Privacy Rights Act. California residents can find California specific data privacy information at APNS's CCPA Privacy Policy at apnshealth.com. The policy informs you of the categories of Personal

Information that we collect and the purposes for which those categories of Personal Information are used. Open Payments Database. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. This database can be found at https://openpaymentsdata.cms.gov.

I understand all of the above statements and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

_____ _____

Signature Date

_____

Print Name

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