NEPHROLOGY ASSOCIATES OF SYRACUSE, PC

Adebowale O. Oguntola, MD
Philip T. Ondocin, MD
Matthew G. Chaffin, MD
Simardeep S. Mangat, MD
Bala K. Murthy, MD
Antoine Azar, MD

Marcia H. Ryder, RN, NP
Jacquelyn A. Spencer, RN, NP
Alyssa C. Miles, PA
Tracy A. O'Neill, PA
Joanna A. Woodruff, RN, AGPCNP

Anne E. Zaccheo, MBA, FACMPE
Practice Director

2020 FINANCIAL AND ADMINISTRATIVE AGREEMENT

FINANCIAL CONSENT

Thank you for choosing NEPHROLOGY ASSOCIATES OF SYRACUSE, PC to be your Provider. As a patient you have certain responsibilities in regard to your insurance contract:

1.) To pay amounts not covered by your policy including applicable copays, co-insurance and deductibles.

2.) To be knowledgeable about your plan's covered and non-covered services.

3.) To provide your provider's offices with accurate and up to date insurance coverage.

By signing this patient financial agreement, you agree to be billed as a self-pay patient should you fail to supply valid, accurate insurance information at the time of service.

Due to strict timely filing rules and government regulations, you also agree to notify us right away- no later than 30 days after you receive notification that you are eligible for additional coverage(s) including Medicaid, Medicare, Medicare Advantage plans or other supplemental policies. Should you fail to give us timely notification of additional coverage (including Medicaid or Medicare eligibility), you will be considered a self-pay patient and agree to be held personally responsible for payment of your charges.

Payment is expected at time of service. If full payment is not possible at time of service, a partial payment is expected. Payment plans may be set up on an individual basis with our Billing Staff. Please provide current insurance identification card (s) and valid identification at each visit, and please keep us updated on your current cell number and address.

INSURANCE & PAYMENTS - It is the patient's responsibility to find out if NAS participates with your insurance company. Each insurance company has many plans that can vary even within one employer. We have a list of participating insurance carriers on our website at www.nephrologysyracuse.com. Whatever is not covered by your insurance plan(s) is your responsibility. You must present your insurance card(s) at each visit. Your co-pay is due at the time of service. We accept cash, checks, money orders, Master Card, Visa, Discover and American Express.

PATIENT CONSENT AND HIPAA ACKNOWLEDGEMENT

I hereby authorize Nephrology Associates of Syracuse, PC (NAS) to release all information necessary to complete insurance forms and to secure payment. I also authorize payment for medical services to be sent directly to Nephrology Associates of Syracuse. I hereby authorize

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Nephrology Associates of Syracuse, PC to place my signature on file with Upstate Medicare Claims Division for the purpose of billing Medicare. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I accept responsibility for all medical charges not covered by insurance. I agree to pay any co-pays and/or balances at the time of service unless other arrangements are made in advance. I accept financial responsibility. Correspondence regarding medical charges will be sent to the address of the insurance holder. I assume responsibility for all reasonable collection costs, including attorneys' fees. I authorize Nephrology Associates of Syracuse, PC to leave messages on my answering machine/voice mail pertaining to appointments or payment issues and to send correspondence to the address provided for the insurance holder unless other arrangements are made in advance. I understand that NAS will utilize text messages & emails to notify patients about future appointments and other important notifications if needed. I consent to the release of any medical information about me and any other individual for whom I can give consent to my health plan and any health care providers involved in caring for me or such individual, as reasonably necessary for my health plan or my providers to carry out treatment, payment or health care operations. (** This does not replace the required HIPAA written authorization for applicants other than treatment, payment, of health care operations. **) I acknowledge that I have a right to request a chaperone for today's office visit or any future visits with NAS. I have been offered or received a copy of the Notice of Privacy Practices.

NOTICE OF CANCELLATION POLICY AND NO-SHOW FEES FOR APPOINTMENTS

At Nephrology Associates of Syracuse, we remind you of your office appointment three days before either by text, email or phone. We understand that there are times when you must miss an appointment due to an emergency, or family or work obligation. If you cannot make your appointment, we ask that you please contact us at least 24 hours ahead of time to reschedule your appointment.

Methods to contact us include responding to a phone call or text notice, or a phone call to our office during normal business hours (Monday – Thursday 8:00 am - 4:30 pm and Friday 8:00 am - 4:00 pm).

Patients who fail to show up for their appointments or cancel less than 24 hours in advance will be charged a $30 no show fee that is not covered by insurance. This fee may be required to be paid prior to scheduling further appointments at the practice. Multiple no showed or cancelled appointments may lead to dismissal from the practice. We require that all active patients have a scheduled appointment on the books to ensure that they are not lost to follow up care.

Thank you for your understanding.

I have read and understand the policy Nephrology Associates of Syracuse has regarding no shows and cancellations.

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PATIENT PORTAL: Our Patient Portal and online payment is available via our web site at www.nephrologysyracuse.com.

AGREEMENT TO FINANCIAL AND ADMINISTRATIVE POLICY

I have reviewed and been given an opportunity to ask questions about the Financial and Administrative Policy and agree to the terms of payment due.

_____ _____

Patient Signature Patient's Date of Birth

_____

Printed Name of Patient

OR:

Legal Guardian Signature: _____

Legal Guardian Printed Name: _____

Date: _____