FINANCIAL POLICY

We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and agree to prior to any treatment. WE ACCEPT CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

HMO Plans and PPO Plans with which we are contracted: All co-pays and must be satisfied at every visit. Your co-insurance and unmet deductible are your responsibility, and payment is due at the time of your treatment or upon receiving notification from your insurance of the amount owed by you. Due to contractual and uniform compliance issues with your insurance company, there are no exceptions to this policy. You are responsible for obtaining authorization and approval for treatment with your Medical Group or PCP prior to treatment.

Medicare: We accept Medicare assignment. Medicare pays 80% of the allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance for the remaining 20% of the Medicare allowed payment as a courtesy; however, you are responsible for any remaining balance regardless of payment from a secondary insurance. You will not be billed more than the Medicare-approved amount for covered services.

Cash patients are accepted on an individual basis. All services must be paid in full at the time of your treatment. Our office can provide you with an estimate of the cost of treatment prior to your visit with the physician. We are willing to extend a discount off our usual and customary fees for full payment at the time. the services are rendered. The discounted price for your initial consultation (new patient visit) is $300 and follow-up visits (established patient visit) are $200. Again, these services must be paid for at the time of the services being rendered or the discount is not applicable.

We will bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance may be transferred to you and/or the guarantor listed on the Patient Information form. If you are unable to make the payment in full, contact the billing department immediately to make payment arrangements. You may be required to enter into a repayment agreement for any unpaid debt prior to scheduling an appointment. In the event legal action is necessary to collect an outstanding balance, you will be responsible for reasonable attorney fees and legal costs, as permitted by law. Delinquent accounts may accrue interest at the legal rate allowed by law.

You are responsible for notifying us of any changes to your healthcare coverage. Services may be cancelled if we do not accept your current insurance plan. If your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of network deductible or coinsurance amounts.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
Returned Checks: A $25.00 fee will be charged for any returned checks. We will be unable to accept your check for any services thereafter. If any discount was applied to the price of the service(s) the discount will

be revoked, and you will pay the full price of the service(s) rendered in addition to the fee.

Medical Records: All Medical Record requests are subject to a clinical preparation fee of $25.00 for legal cases, personal injuries and other matters that involve your attorney requesting your records.
Paperwork Fees: We do charge for completing paperwork on your behalf. This fee covers our costs and time involved in accessing your medical records, reviewing the documents, completing, and signing the forms. We require a $40.00 fee. These fees must be paid prior to the forms being completed. Paperwork can take 3-5 business days to complete.

Notification: Credit Reporting Prohibition for Medical Debt
A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

Delinquent accounts will be assigned to an outside collection agency for collection action. You will be required to enter into a repayment agreement for any collection accounts with the collection agency prior to scheduling an appointment. In the event legal action is necessary to collect an outstanding balance, you will be responsible for reasonable attorney fees and legal costs, as permitted by law. Delinquent accounts assigned to an outside collection agency may accrue interest at the legal rate allowed by law.

**Exceptions to Credit Reporting Prohibition: Under CA law, the holder of this medical debt contract is permitted to report the debt to consumer credit reporting agencies in the following cases:

- Direct Insurer Payment: When your health insurer pays you directly instead of Murrieta Valley Surgery Associates and Murrieta Valley Surgery Associates does not receive your payment within 60 days of the insurer's payment notification to you or one year from the initial billing date, whichever occurs later.
- Cosmetic Surgery Debt: When the medical debt results from cosmetic surgery, as defined in California Health and Safety Code Section 1367.63.

I have read and understand the policies and fees, and I agree to these terms. I hereby give a lifetime authorization for payment of insurance benefits made directly to Murrieta Valley Surgery Associates. Inc. (MVSA). I understand that I am financially responsible for all charges and fees whether or not they are covered by insurance. I hereby authorize MVSA Inc. to release all information and medical records necessary to secure payment for my services. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature: Date: