FINANCIAL POLICY

Chris Pate, MD/Biosymmetry, PC believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to provide the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT** is expected at the time of your visit. We will accept cash, check, or credit card.
2. **INSURANCE:** We are not participating providers with any insurance companies. The insurance contract is between the patient and the insurance company and ultimately the patient is responsible for payment in full.
   Our services would be considered out of network, since we are a non-participating provider. Your insurance company should send payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products available, our staff cannot guarantee your eligibility and coverage for our services. Be sure to check with your insurer's member benefits department about services and physicians before your appointment.
3. **Medicare:** Dr. Pate and/or BioSymmetry is not a participating provider with Medicare and has formally opted out of participation. This means that no service performed at BioSymmetry or in conjunction (ie: Lab services) with BioSymmetry, can be filed with Medicare for reimbursement by the patient or by BioSymmetry. Services performed by Dr. Pate and/or Biosymmetry are the full financial responsibility of the patient.
4. **INSURANCE PRIOR AUTHORIZATIONS:** We will make 1 attempt to secure a prior authorization approval from your insurance company. If your insurance requires a prior authorization to be obtained for medications you are prescribed by our clinic, there will be a **$15.00** charged to you for each prior authorization occurrence, successful or un-successful.
5. **RETURNED CHECKS** will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving additional services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collection action. All bad checks written to this office are subject to collections and will be prosecuted in Wayne County.
6. **ACCOUNTING PRINCIPALS** Payment and credits are applied to the oldest charges first.
7. **FORMS FEES:** completing insurance forms, copying medical records, etc… Requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, or for extra written communication by the doctor. The charge will be determined by the complexity of the form, letter, or communication. Base form charges are $10 per occurrence plus and applicable postage. Postage is additional and payment is required in advance. Copying fees for Medical Records is $10 for the first twenty (20) pages and $0.50 per page in excess of twenty. Biosymmetry, PC will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and after patient has signed a authorizing records' release form.
8. **RESPONSIBILITY FOR PAYMENT:** I understand that I, personally, am financially responsible to Biosymmetry, PC for all charges.
9. **Services and Items covered in agreement:** All labs ordered by Dr. Pate relating to hormone replacement, the initial physician visit and as needed during therapy, implant procedures and

pellets, (not to exceed 5 implants/labs per year for men and not to exceed 8 implants/labs for females; additional charges will apply for implants exceeding these amounts) and prescription orders that are ordered by Dr. Pate. For patients using prescription creams, the agreement will include the initial physician visit and as needed, labs ordered during this agreement, and prescription ordering. Additionally, for men using creams and requiring aromatase inhibitors, these will be included during agreement.

10. **REFUNDS:** No refunds once services are rendered. There are no guarantees of results. There is a belief these services are beneficial to individuals that meet weight loss, hormone replacement lab criteria and exhibit symptoms indicating possible hormone deficiencies. For advance payment hormone replacement patients that no longer wish or cannot continue replacement, there is option for a graduated refund. The refund amount will be calculated as follows: 100% refund if patient cancels and has no services, 60% refund after 1st implant is completed, 40% refund after 3 months, 25% refund after 6 months, 10% refund after 9 months, and 0% refund after 10 months. These prorated percentages are based on yearly replacement therapy being paid at initial visit. If patient used some form of credit card, Visa, Mastercard, Discover, American Express, Care Credit or similar interchanges, there will be a $175.00 to $250.00, depending on specific carrier, non-refundable charge deducted from the refund amount. The request for refund must be made in writing. Refunds will be issued within 30 days of request.
11. **RELEASE OF INFORMATION:** I hereby authorize the and direct Biosymmetry, PC/Chris A. Pate, MD, to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.
12. **COLLECTION FEES:** I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court cost, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature page to follow

HIPPA-Health Insurance Portability and Accountability Act

YOUR RIGHTS – Under the federal Health Insurance Portability and Accountability Act (HIPPA), you have the right to request restrictions on how we use or disclose your personal information for treatment, payment, or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your health care or the paying of your care.

ACCESS TO YOUR PERSONAL HEALTH INFORMATION – You have the right to inspect and or/obtain a copy of your personal health information we maintain in your designated medical records. You must sign a release of medical records consent form to obtain these records.

FAMILY, FRIENDS, AND PERSONAL REPRESENTATIVES – With your written consent we may disclose to family members, close personal friends, or another person you identify your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best physical interest, we may disclose your personal health information to the public or private entities to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES: We are permitted or required by law to use or disclose your personal health information, without your authorization, in the following circumstances:

- For public health activities (reporting of disease, injury, birth, death, or suspicion of child abuse, neglect, or domestic violence)
- To government authority if we believe and individual is a victim of abuse, neglect or domestic violence.
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions)
- For judicial or administrative proceedings (for example pursuant to a court order, subpoena or discovery request)
- For law enforcement purposes (i.e. reporting wounds or injuries or for identifying or locating suspects, witnesses or missing persons)
- To advert a serious threat to health or safety under certain circumstances
- For military activities if you are a member of the armed forces or an inmate or individual confined to a correctional institution.
- For compliance with worker’s compensation claims

We will adhere to all state and federal laws or regulations that provide protections to your privacy. We will only disclose AIDS/HIV related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by law.

Signature page to follow

Patient Consent to Communicate by Email Policy

Biosymmetry has adopted a policy that requires their staff to obtain authorization from the patient to communicate with you by use of email. This policy is to protect the patient and to also protect the Biosymmetry Provider's staff from violating the patient's confidentiality. If the Biosymmetry Provider's staff does not have a signed consent on file, the staff may not communicate with you by email.

By completing the consent below, you hereby authorize the staff to email messages regarding treatment, test results, appointment reminders or other necessary information.

Signature page to follow

Patient Consent to Leave Detailed Message/Information Policy

Biosymmetry has adopted a policy that requires their staff to obtain authorization from the patient to leave detailed messages for the patient. This policy is to protect the patient and to also protect the Biosymmetry Provider's staff from violating the patient's confidentiality. If the Biosymmetry Provider's staff does not have a signed consent on file, the staff may only leave their name and a phone number on an answering machine asking you to call them back.

By completing the consent below, you hereby authorize the staff to call and leave their name, Biosymmetry Provider's name, and additional information on an answering machine or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

Signature page to follow

Maintenance of Preventative Medicine and Cancer Surveillance

A requirement for acceptance and continuation in the bio-identical hormone replacement program is adherence to routine cancer/prostate screening. You must have routine physical examinations including a PAP and/or mammograms for females or prostate examination, and/or PSA testing for males. Your signature below indicates that you will comply by obtaining the cancer/prostate screening from your primary care physician within three months of beginning the Bio-Identical Hormone Replacement Therapy Program per the current screening guidelines, which can be obtained, and followed with your primary care physician.

I accept all terms and conditions of this program.

Signature page to follow

Applies to individuals covered by Medicare for your primary or secondary coverage
IN COMPLIANCE WITH 42 U.S.C. §1395a; 42 C.F.R. § 405, SUBPART D

This contract is entered into by and between Chris A Pate, MD (hereinafter called "physician"), whose medical offices are located at 2280 Hwy 70 West, Goldsboro, NC 27530 (hereinafter called "beneficiary")(identified by signature page), shall become effective on date of signature.

Physician Obligations

The physician acknowledges that he is not excluded from Medicare under sections 1128, 1156, 1892 or any other section of the Social Security Act.

The physician acknowledges that this contract shall not be entered into with the beneficiary, or the beneficiary's legal representative, during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The physician acknowledges that he must retain this contract (with original signatures of both parties to this contract) for the duration of the opt-out period, and that it shall be made available to the Centers for Medicare and Medicaid Services (CMS) upon request.

The physician shall provide a copy of this contract to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

The physician acknowledges that [he or she] must enter into a contract for each opt-out period.

Beneficiary Obligations

The beneficiary, or his or her legal representative, accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

The beneficiary, or his or her legal representative, understands that no payment will be provided by Medicare for items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

The beneficiary, or his or her legal representative, understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

The beneficiary, or his or her legal representative, agrees not to submit a claim, nor ask the physician to submit a claim, to Medicare for Medicare items or services, even if such items or services are otherwise covered by Medicare.

The beneficiary, or his or her legal representative, has entered into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare and for whom payment would be made by Medicare for their covered services, and that the beneficiary has not been compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

The beneficiary, or his or her legal representative, understands that Medigap plans do not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

The beneficiary, or his or her legal representative, acknowledges that a copy of this contract has been provided to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

I understand that during the opt-out period, a Medicare Advantage plan may not by law make any payments to the physician for any Medicare items and services furnished to the beneficiary under this contract.

Chris A. Pate, MD
Name of Physician (printed)

Signature page to follow