Cost Share Waving by Insurance Carriers
Related to COVID-19 visits and tests

The following insurance carriers have confirmed that they are waiving copays and deductibles for tests and visits related to COVID-19. Avecina Medical will not collect copays or deductibles for these carriers. If for any reason, the patients' individual plan denies any claims, the associated costs are the responsibility of the patient. Here are the carriers that are participating in the Cost Sharing program:

Cost Share Waivers Extended to April 20, 2021
Avmed
Aetna
United Healthcare
Florida Blue (**OUT OF STATE PLANS NOT INCLUDED**)
Cigna
Humana –**EXCLUDES MEDICAID –WE DO NOT ACCEPT HUMANA MEDICAID**
Simply Health
Aetna Better Health
Medicare (**after deductible is met**)
Tricare

Insurance Carriers NOT participating in Cost Share waiving:

Out of State Blue Cross Blue Shield plans
Champ VA

I agree that Avecina Medical will file these claims on my behalf and will make every attempt to have the insurance carriers cover the charges associated with the visit and test. Avecina will refund patients any funds paid by the insurance carriers that would have gone towards their out of pockets costs. Also, I agree that if my insurance carrier denies the claim for any reason, the charges associated with the visit and test are the patient's responsibility.

Please note: Many self-funded employer groups have opted out of cost waiving for their members.

Patient Name: _____ Date: _____

Patient/Responsibly party Signature: _____

(Please Complete ALL Sections)

COVID REGISTRATION

Patient Information

Date:_____

Name:_____

DOB:_____ Age:_____ M / F

SSN:_____

Address:_____

_____

City, State, Zip:_____

PHONE

Home:_____ Cell:_____

Work:_____

Email:_____

EMERGENCY CONTACT

Name:_____

Phone #:_____

Health Insurance Information

Insurance Company:_____

Policy #:_____

Group #:_____

Insured Name:_____

DOB:_____

Relationship to Insured (circle one)

Spouse Child Parent Other

GUARANTOR (REQUIRED if patient is a minor)

Name:_____

DOB:_____

SSN:_____

Method of Payment

(Co-Pay, Coinsurance, Deductible)

CASH (must be exact change) OR CREDIT CARD

ALLERGIES (Medications & Food)

_____

_____

MEDICAL HISTORY (Medical Conditions & Surgeries)

_____

REASON FOR VISIT

_____

_____

MEDICATIONS (Over the counter & Prescribed)

_____

_____

DURATION OF ILLNESS

_____

****CLINICAL INFORMATION******

Blood Pressure: _____

Pulse Rate:_____

RR: _____Pulse Ox:_____

Temp:_____

Height_____ Weight _____

Work Accident? YES /NO Auto Accident? YES / NO

PHARMACY

_____

HOW DID YOU HEAR ABOUT US? _____

PRESCRIPTION DRUG POLICY

Due to the nature of our practice, please b advised that the physicians of Avecina Medical 1) Do Not provide narcotics for chronic pain management. 2) Do Not dispense OXYCODONE or any other class 2 drug. 3) Do Not authorize refills for antibiotics without a follow up visit for re-evaluation of your medical condition. 4) Do Not provide primary care management of chronic medical conditions. 5) Are Not responsible for lost or stolen prescriptions.

By signing this registration form you are stating that you understand this medication policy. If you have any questions regarding this policy, please do not hesitate to speak with a member of the management team.

Patient/Responsible Party Signature_____

Date: _____

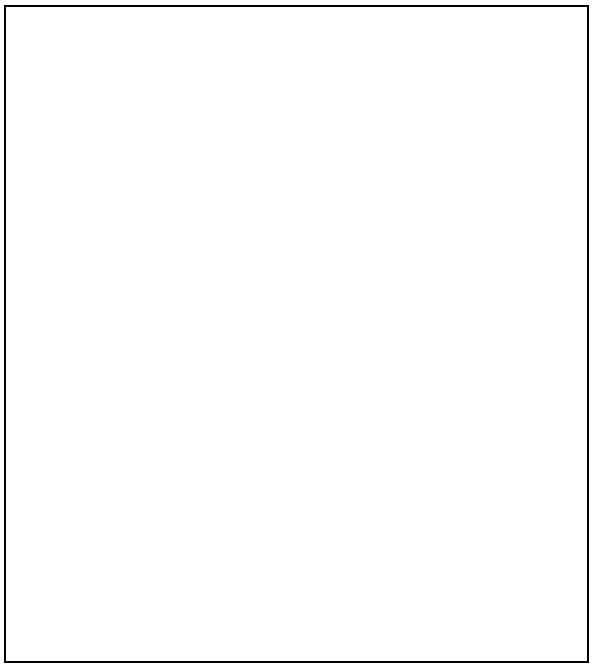
In-Office COVID-19 Test

Method: Antigen Nasopharynx Swab (**Please print legibly**)

PATIENT NAME:_____

ADDRESS:_____

DOB:_____ **Phone(MUST BE CELL #):**_____



By signing below, I authorize to receive a picture message of my COVID-19 results to the phone number provided above. ****Allow 24 hours for results**** If positive, I acknowledge that I will quarantine for 14 days. If you are a healthcare provider or someone with significant face to face contact with others, per CDC guidelines that two negative tests must be done 24 hours apart to be considered cleared of COVID-19. I understand that no test is 100% accurate and it takes 72 hours after exposure for a test to show positive.

I agree that a $15 fee will apply for any canceled appointments. There is no refund once the test has been performed.

PATIENT SIGNATURE:_____ **DATE:**_____

CONSENT FOR TREATMENT AND MEDICAL RECORDS RELEASE

CONSENT and Authorization for Routine and Treatment:
I hereby consent to and authorize Avecina, and my physician or healthcare providers (both herein Avecina) to provide medical care necessary for treatment of my medical condition.

Patient or Responsible Party _____ (Please initial)

Assignment of Benefits:
I hereby assign Avecina and my providers payment from all third party payers with whom I have coverage or from whom benefits are or may become payable to me, for the charges of my healthcare services I receive for, related to, or connected with this visit and any future visit for which I have medical insurance coverage.

Patient or Responsible Party _____ (Please initial)

Consent and Authorization for Release of Information: Cooperation:
I hereby authorize Avecina and my providers to release copies of my billing and medical records, and applicable healthcare information, to ensure payment for healthcare services I receive for, related to, or connected to this visit(s), to secure additional treatment if needed and to otherwise facilitate healthcare operations related to the following persons or entities: any Avecina provider, my referring or treating providers, the Guarantor to my accounts, and third party payers* or their agents. I also authorize the release of my healthcare information to regulatory entities and accrediting organizations as necessary to secure payment for service provider to me.

Patient or Responsible Party _____ (Please initial)

Guarantor/Patient Agreement:
I hereby agree to the following: (1) I am responsible for the charges of all healthcare services the "Patient" receives for, related to, or connected with this visit(s), and same are due and payable at the time of discharge or discontinuation of treatment. The charges I agree to pay are readily available from any Avecina staff member and I am fully aware at the time the healthcare service are provided. (2) If Avecina bills third party payers*, they do as a courtesy, and Avecina may demand payment in full of any balance due, at any time. (3) I understand that Avecina may bill me separately. (4) If I am more that thirty (30) days overdue in the payment of any bill, **a finance charge of up to $10 per month will accrue on the unpaid balance every month until paid in full**. (5) If I am more than ninety (90) days overdue on the payment of the final bill, I may be declared in default, and the overdue account may be referred to a collection agency, in which case I agree to pay attorney's fees, court costs and/or collection agency fees associated with the collection process.

I acknowledge and agree that Avecina and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephone number I have provided to you, and any other telephone number associated with my account, including wireless or mobile numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Avecina if I have given up ownership or control of such telephone number.

Patient or Responsible Party _____ (Please initial)

Our staff will do everything possible to verify your insurance benefits and eligibility. If treatment is AFTER HOURS or on WEEKENDS AND WE ARE UNABLE TO VERIFY YOUR MEDICAL INSURANCE COVERAGE
Please be advised that due to the nature of our practice, payment for physician services is expected at the time of service. We accept Cash, Debit Cards, MasterCard, Visa, American Express, Discover, and CareCredit. Avecina **accepts most insurance plans and will be happy to file your insurance, provided that eligibility, deductible and co-payment amounts can be verified prior to seeing the physician. Otherwise, PAYMENT IN FULL WILL BE EXPECTED AT THE TIME SERVICE IS RENDERED.**
For your convenience, Avecina can either submit the claim on your behalf to your insurance company or we will provide the appropriate form so that payment can be reimbursed to you by your insurance or applied toward your annual deductible, whichever is applicable.
PAYMENT POLICY MUST BE ACKNOWLEDGED AND ACCEPTED PRIOR TO SEEING THE PHYSICIAN

Payment Policy Acknowledge and Accepted by Patient or Responsible Party _____ (Please initial)

*** Third party payers include, but not limited to, coverage available from, Medicare, Tricare, or governmental programs; health, accident, automobile, or other insurance; worker's compensation, HMO (commercial, Medicare); self-insured employers; and any sponsors who may contribute payment for services.**

By signing below, I acknowledge that I have read, understand, and agree to the foregoing as applicable to me, which shall also apply to Patient's child(ren) or legal dependent.

Patient or Responsible Party: **Date:**

HIPAA NOTICE

PATIENT NAME: _____ DOB: _____

SSN: _____ PHONE NUMBER: _____

ADDRESS: _____

Acknowledgment of Receipt of Privacy Notice for Avecina Medical

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice and/or a copy of the notice is available for review at your request.

_____ _____

Signature of Patient or Legal Representative *Date*

Request for an *Exception* to the disclosure rules regarding the Release of Protected Health Information (PHI)

☐ Exception for Disclosure (Individuals or means where by PHI may be released)

I authorize the following people to be involved in my care. This consent for disclosure includes both health and financial information as it relates to my care.

Individual's Name (Please Print) *Relationship to Patient*