CONNECTICUT COLON & RECTAL SURGERY, LLC

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Connecticut Colon & Rectal Surgery, LLC as your healthcare provider. The medical services you seek entails a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, co-payments, and patient billing. By signing below and/or by receiving medical services from **Connecticut Colon & Rectal Surgery, LLC** you agree:

1. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier or our financial policies, which are not otherwise covered by supplemental insurance.

    a. The **patient is responsible** to provide Connecticut Colon & Rectal Surgery, LLC with current, accurate billing/insurance information concerning your primary, secondary, and tertiary insurance at the time of check in and to notify Connecticut Colon & Rectal Surgery, LLC of any changes in this information. Current identification and insurance benefit cards are to be presented at each office visit.

    b. **Co-pay is to be paid at the time services are rendered.** This is a contractual agreement between the patient and their health insurance. Connecticut Colon & Rectal Surgery, LLC also has a contractual agreement with the health insurance to collect co-pays at the time of service and are required to report to the health plan of any enrollees failing to pay the co-pay.

2. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) you receive services in excess of such authorization or referral; (ii) your health plan determines that the services you received are not medically necessary and/or not covered by your insurance plan; (iii) your health plan coverage has lapsed or expired at the time you receive services. If you are not familiar with your plan coverage or have any questions regarding your financial obligation, we recommend you contact your carrier or plan provider directly.

    a. **It is the patient's responsibility to determine whether an insurance referral is required!** The referral can be requested from your primary care physician. If you are unable to obtain the referral, you will be rescheduled.

3. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the

visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be rescheduled by Connecticut Colon & Rectal Surgery, LLC.

4. We may verify your insurance benefits or submit your claim to your insurance carrier as a courtesy to you. You agree to facilitate payment of claims by contacting your insurance carrier when necessary. Without waiving any obligation to pay, you assign Connecticut Colon & Rectal Surgery, LLC for application onto your bill for services. All of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. You authorize this office and associated physicians, staff, and hospitals to release patient information acquired in the course of your examination and/or treatment including but not limited to any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related to your treatment. This includes itemization or any charges and payments on your account that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they require to participate in your care. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. This office does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

5. If your insurance carrier does not remit timely payment on your claim, which can take up to 90 days, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit the same to Connecticut Colon & Rectal Surgery, LLC until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize this office to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account. or on any account for which you are a Financial Responsibility Party, and any remaining balance will be returned to the payor.

    a. If your insurance rejects, denies, or covers only a portion of treatment, the patient will be responsible for payment of the balance due.

6. You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). You may generally expect this billing statement within thirty (30) days after your insurance company has responded to a submitted claim. You must notify us of any errors or objections to the billing statement within thirty (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If there is a problem with your account, it is your responsibility to contact the Patient Accounts Staff to address the problem or to discuss a workable solution.

a. Prior to a procedure, payment of an outstanding account balance will be requested and should be received unless arrangements have been made with our Billing Office.

7. Whether or not you have insurance or are self-pay, payment of any account balance is due within thirty (30) days of receipt of your billing statement. The balance of any account not paid within ninety (90) days will begin to accrue interest at the rate of 18% APR or the maximum allowed by applicable law, whichever is lower. If any balance on your account is over ninety (90) days past due, your account will be in default and auto referred to a collection agency and you will be responsible for the additional 15% fee associated with this action.

8. We accept payments by cash, check, money order, debit cards and credit cards (Visa and Mastercard).

    a. **Payment by Check.** If payment is made by check and it is returned or declined for any reason (i.e., insufficient funds, closed accounts, stopped payments), your account will be charged a surcharge of $35.00 or up to the applicable state maximum legal limits, whichever is lower, in addition to any costs assessed or charged by any depository institution.

    b. **Payment by Credit Card/Credit Card on File**. When you pay by Credit Card to be held on file, you agree to keep the credit card information current, and you authorize our office to securely store your credit card information, and only charge it should you have an outstanding balance or any leftover balance from a processed claim in the future. The storage system used is fully compliant to the highest level of credit card storage security regulations. Once stored, only the last 4 digits of your credit card are viewable by personnel. You understand that you are responsible for all charges for services that you receive from Connecticut Colon & Rectal Surgery, LLC and if the patient responsibility portion of your charges (including charges applied to your deductible and/or coinsurance) is not paid in full within thirty (30) days following receipt of the financial responsibility statement, then Connecticut Colon & Rectal Surgery, LLC will bill your stored credit card for the outstanding balance due.

11. **Medicare.** Connecticut Colon & Rectal Surgery, LLC is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or 20% co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare. We may submit a claim to any supplemental plan as a courtesy to you, so long as you provide all necessary policy information.

12. **Medicaid.** If you are a Medicaid patient, you must present a valid eligibility card at the time of registration and prior to the time of service. Your eligibility status will be verified. Without verification of coverage, you will be responsible for the full/entire balance of your account. As a courtesy to you, your account will be billed to Medicaid when we receive all necessary information. You are responsible for non-covered portions and spend down requirements associated with your individual coverage. If at any time you are not eligible for Medicaid coverage and wish to be seen, you will be treated as a self-pay patient and must make payment at the time of service

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13. **Additional Charges**. Patients may incur and are responsible for the payment of additional charges at our discretion including but not limited to: (i) charges for returned checks; (ii) charges for a missed appointment without a 48-business hour advance notice; (iii) charges for extensive phone consultations and/or after-hours phone calls requiring treatment, or prescriptions; (iv) charges for copying and distribution of patient medical records; (v) charges for extensive forms preparation or completion; (vi) charges associated with the completion of medical leave forms such as but not limited to, FMLA, STD, disability forms, serious health condition forms; or (vii) any costs associated with collection of patient balances, all as allowed by law.

14. **Non-payment on Account**. Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that Connecticut Colon & Rectal Surgery, LLC has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) all court costs and fees (but only to the extent allowed by law); and (iii) a collection fee to be charged under separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. You acknowledge that any such interest assessed on the account will be a late fee as a result of default or delinquency on your account, and is not deemed interest as part of a credit transaction. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history; and related portions of your account, including the fact that you received treatment at our offices, may become a matter of public record. Failure to comply with any of these policies may also result in a Credit Withdrawal of Care. Furthermore, once you are delinquent 90 days or more, at our discretion, this office may require that for future appointments, a deposit of $100 be made for anyone with a deductible and/or an HSA or other credit card be left on file. Finally, we also reserve the right to withdraw you from future care, i.e., Discharge you from the practice for repeated failure to pay bills.

15. **Minor Patients**. The parent/guardian of a minor, under the age of 18, is responsible for payment of the minor's account balance. A minor who is not accompanied by a parent/guardian will be denied any non-emergency treatment unless charges for the treatment have been pre-authorized. Responsibility for payment of treatment of minor children, whose parents are divorced, rests with both parents. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of this office.

16. **Authorization to Contact**. You authorize personnel of this office to communicate by mail, answering machine messages, and/or e-mail according to the information provided in your patient registration information. Connecticut Colon & Rectal Surgery, LLC or any agent or servicer of your patient account, may use any information you have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers to contact you for purposes related to your account, including debt collection. You authorize us to use this information in any manner consistent with the information you have provided, including mail, telephone calls, e-mails, or text messages. You expressly consent to any

such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages, even if you are charged for the contact.

17. **Financial Responsibility Party**. If this or a separate Financial Responsibility Statement is signed by another person, on your account, then that co-signature remains in effect until canceled in writing. Cancellation in writing shall become effective the date after receipt, and shall apply only to those services and charges thereafter incurred. By signing as Financial Responsibility Party, you hereby guarantee the full and prompt payment to Connecticut Colon & Rectal Surgery, LLC. of all indebtedness of Patient to Connecticut Colon & Rectal Surgery, LLC whether now existing or hereafter created (the "Indebtedness"); and you further agree to pay all expenses, legal or otherwise. incurred by Connecticut Colon & Rectal Surgery, LLC in collecting the Indebtedness, in enforcing this guaranty, or in protecting its rights under this guaranty or under any other document evidencing or securing any of the Indebtedness. This guaranty shall be a continuing, absolute and unconditional guaranty, and shall remain in force and effect until any and all said Indebtedness shall be fully paid. There shall be no obligation on the part of Connecticut Colon & Rectal Surgery, LLC at any time to first exhaust its remedies against patient, any other party, or any other rights before enforcing the obligations of the Financial Responsibility Party.

18. **Procedure and Surgery.** Why am I receiving more than one bill for the same procedure/surgery? There are a number of separate charges associated with your surgical procedure. You MAY receive charges from several companies.

    a. Procedure Fees are broken down and billed separately as follows:
        - Professional Fee – Physician's fee for performing the procedure
        - Facility Fee – The fee for the use of the facility where the procedure is performed.
        - Anesthesia – The fee for the anesthesiology portion of the procedure
        - Pathology – Services for culture and tissue specimens removed during surgery that requires further examination
        - Dependent on your individual insurance carrier, you may receive a bill from a third party Durable Medical Equipment and Medical Implant Device company

    b. Procedures performed by the physicians of Connecticut Colon & Rectal Surgery, LLC at an ambulatory surgical center or at the hospital are broken down and subject to third-party billing. Connecticut Colon & Rectal Surgery, LLC is only responsible for billing the professional fee. **Connecticut Colon & Rectal Surgery, LLC WILL NOT BE ABLE to address any questions or concerns regarding the billing or patient responsibility/statements from the facility, anesthesiology, or laboratory**. These questions and concerns must be made directly to the company you have received the bill from and to your insurance carrier.

19. **No-Show and Cancellation Policy.** Connecticut Colon & Rectal Surgery, LLC charges a $50 fee for missed appointments and a $500 fee for missed procedures if I do not call to cancel or reschedule at least 48 business hours prior to the appointment time. Business hours are considered Monday through Friday during 9:00 am to 4:00 pm and exclude weekends and federal holidays. This fee is not covered by insurance and will be will be your responsibility.

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Financial Policy Acknowledgement

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of this PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to specified terms; (ii) I agree to pay all charges due (or to become due) to Connecticut Colon & Rectal Surgery, LLC for the below patient's care and treatment, including copayments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any service rendered; (vi) if I fail to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report.

I further agree that a photocopy of this Patient Responsibility Financial Agreement shall be as valid as the original. **ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.**

_____ _____
Patient Signature Date

_____
Patient Printed Name

_____ _____
Parent or Guardian Signature Date
If the patient is a minor (under the age of 18) or has a guardian/conservator, this must be signed by the parent or legal guardian.