FINANCIAL POLICY

Thank you for choosing UKSM-Wichita Medical Practice Association (UKSM-W MPA) for your medical care. We appreciate that you have entrusted us with your healthcare, and we are committed to providing you with the best patient care possible. Because healthcare benefits and coverage options have become increasingly complex, we have developed this financial policy to help you better understand your rights and responsibilities as a patient.

INSURANCE COVERAGE
Insurance policies are an agreement between the patient and his or her insurance company. It is the responsibility of the patient/guardian to know his or her insurance benefits which includes copayments, deductibles, and coinsurance. For the convenience of the patient, we will file your claims with the insurance company -provided by the patient/guardian. It is the responsibility of the patient/guardian to make accurate and detailed insurance policy information available, within the timely filing limits of the plan, to enable processing of claims. If accurate insurance policy information is not provided within the timely filing limits of the insurance plan, the patient/guardian may become financially responsible for charges. The patient will be considered self-pay if valid insurance policy information is not received. The patient is responsible for notifying our office of any insurance policy updates.

WORKERS COMPENSATION
Appropriate referral and all necessary accident information must be received at the time of appointment scheduling. An injury form is required to be completed in full at the time of visit with all workers compensation information. UKSM-W MPA will file your workers compensation claim if all required information is provided; otherwise, you will be fully responsible for the balance.

PERSONAL INJURY/MOTOR VEHICLE ACCIDENT INSURANCE
UKSM-W MPA does not accept liens for assignment of payment in the case of liability actions. An injury form is required to be completed in full at the time of visit with all motor vehicle accident information. We will bill your personal primary automobile insurance for all auto accidents. Our relationship is with you, not your auto insurance company; therefore, it is often necessary for you to inquire on your claim with your auto insurance carrier to ensure payment. Health insurance companies will not pay until a claim has been processed by the automobile insurance.

SELF-PAY
Self-Pay patients are patients without insurance policy coverage. You will be required to complete the self-pay agreement and pay for the professional service on the date of your appointment unless you have been qualified for a federal assistance program or set up a payment arrangement with the billing department prior to your visit. You may also receive a statement for any additional ancillary services you received. A 35% discount may apply to those charges.

Some patients may qualify for a UKSM-W MPA federally funded assistance program. The patient responsible amount will decrease for individuals that qualify for this program, and in some cases, may be reduced to zero. Eligibility is determined based on specific criteria and documentation. Patients who qualify will be billed according to the adjusted schedule. Patients who do not qualify will be billed according to the standard fee schedule.

The Health Insurance Portability and Accountability Act (HIPAA) allows patients to elect to opt-out of using their insurance benefits and pay for services up front. If the patient/guardian chooses to opt-out, they have the right to request restriction of their health information from their insurance company. The patient/guardian must request to fill out the Health Information Exchange Opt-Out Form. If the patient/guardian chooses the election to opt-out of using insurance benefits for services, they must complete the Insurance Opt-Out and Self-Pay Acknowledgment form at every visit and pay for services up front.

COPAY
A copay is a fixed dollar amount that your health insurance requires the patient/guardian to pay upfront for a covered service. Copays are due at the time of service. If you are unable to pay your copay at the time of service, you will still be seen and billed for the copay. We do not turn patients away due to inability to pay at the time of service. For individuals who qualify for the UKSM-W MPA federally funded assistance program, the patient responsible amount may be reduced, including the possibility of a reduced or waived copay.

DEDUCTIBLES AND COINSURANCE
A deductible is the amount you pay for coverage of services before your health insurance plan kicks in. After you meet your deductible, you pay a percentage of health care expenses known as coinsurance. The amount you pay for your deductible and coinsurance depends on the patient's insurance plan. Some services may require payment of deductibles and/or coinsurance. If requested, payment is due by the deadline we provide, which may be before your appointment or on the day of service. For patients who qualify for the federal grant program, payment responsibility may be based on a nominal fee schedule and subject to a cap on total fees for services rendered. These limits are determined by program guidelines and eligibility criteria. Grant participants will not be billed standard deductibles or coinsurance amounts if they exceed the capped fee structure.

PATIENT STATEMENTS
You will receive a monthly statement from us for any remaining balance after all insurance plans on file have processed your claim. Your payment is expected within 20 days of receipt of this statement. Methods of communication, including but not limited to email and text messages, may be used to contact a patient regarding their remaining balance. Patients are opted-in for voice messages, text

messages, and email reminders regarding their balance. To opt-out, please provide verbal or written notice to a UKSM-W MPA receptionist or the business office.

BALANCES AND PAYMENTS
We accept payments via cash, check credit card, and Care Credit. If you are unable to pay your balance in full, you can contact our Billing Office to set up a payment plan. To avoid delinquency, our office requires that a formal payment arrangement be established, with consistent monthly payments made toward any outstanding balance. Accounts not paid in full within 90 days will be considered past due. Please note that unpaid balances may be referred to an external collection agency for further action. If you are experiencing financial hardship, you may request to complete a financial assistance application. Eligibility for financial assistance is based on specific income and expense criteria. Upon review and approval, your outstanding balance may be reduced in accordance with our financial assistance guidelines. Patients who do not make payment arrangements or qualify for assistance may be subject to dismissal from our practice. In some cases, this may include immediate family members listed under the same account. However, patients who qualify for the UKSM-W MPA federally funded assistance program may be eligible for additional financial support or fee adjustments to avoid dismissal or collections. Please contact our Billing Office to discuss available options before any action is taken. If your account is sent to a collection agency, you will be responsible for all costs of collection, including interest, court costs, and reasonable attorney's fees. If you're unable to pay the full balance due on your statement, please contact our Billing Office at 316-293-3429 to make payment arrangements.

NO SURPRISES ACT/GOOD FAITH ESTIMATE
UKSM-W MPA will produce a *"Good Faith Estimate"* if requested by the self-pay patient/guardian. Good Faith Estimates provide a quote for the cost of treatment prior to services being performed. The patient may authorize the physician and provider to proceed or halt treatment based upon their current financial situation. Additional details of the No Surprises Act can be provided to the patient upon request.

ADVANCE BENEFICIARY NOTICE (ABN)
You may be asked to sign a waiver of liability or Advance Beneficiary Notice (ABN) for certain services that could potentially be denied for payment by your insurance company despite information from them that a service is covered. If you sign the form and your insurance company does not pay for the service, you are financially responsible for the bill. You have the option to decline any service prior to it being performed.

REFERRALS AND AUTHORIZATIONS
It is the responsibility of the patient/guardian to obtain a referral from their primary care physician prior to the scheduled visit. If a referral was not obtained, the patient/guardian accepts full financial responsibility for services rendered.

ADDRESS AND PHONE NUMBERS
It is the responsibility of the patient/guardian to notify our office whenever there is a change to their address, phone number, insurance, or other contact information. Failure to provide timely updates may delay the billing process and could result in referral to an outside collection agency.

I understand that I am responsible for all charges incurred during my treatment at UKSM-Wichita MPA clinics regardless of insurance coverage. I agree to keep my account current and make any financial arrangements needed. However, if I qualify for the UKSM-Wichita MPA federally funded assistance program, my patient responsible amount may be reduced according to program guidelines, which may include nominal fees or a full waiver of charges.

I authorize payment of medical benefits to UKSM-Wichita MPA for services rendered. I also authorize the physician and provider to release any information required to process insurance claims and understand that the physician and provider may bill my insurance directly for services provided. I understand the UKSM-Wichita MPA Financial Policy and will adhere to the policy.

Patient Name ***(Print)***	**Date of Birth (MM/DD/YYYY)**
Patient Signature	**Date**

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)***	**Relationship/Authority to Sign**
Representative Signature	**Date**