CHOLLA MEDICAL GROUP-RIMARY CARE
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FINANCIAL POLICIES AND ARRANGEMENTS

We recognize the need for understanding in the areas of payment arrangements and insurance filings. We have put together this sheet to address some of these issues and to advise you of our financial policies.

Insurance - Filing/Benefits/Payments

There are numerous insurance plans with which we have contracted to receive payment directly from the insurance company. With these plans, the patient is generally required to make a co-payment and/or meet a deductible and/or co-insurance. If you are covered by insurance, please show us your ID card. Be prepared to make your co-payment, or pay for your services if your deductible has not been met at the time of service. We accept: cash, checks, money orders and all major credit/debit cards. If you are covered by an insurance plan that is not contracted by our office, you will be asked to pay for all services at the time of service.

If you would like us to bill your insurance for you, it is extremely important that you provide us with accurate and updated information at each visit, so your claim can be properly filed. It is your responsibility as a consumer to know what benefits are covered by your insurance plan. Most insurance carriers have numerous plans that cover many types of services. Some injections, visits & services may not be covered by your particular plan. If you have a question, you should contact member services at your insurance company for specific benefit information prior to you visit. Their phone number should be located on your insurance card. This office can not become involved in prolonged insurance negotiations. If your claim is unpaid after 45 days, you will receive a bill requesting payment in full and you will be responsible for further contact with your insurance company. You will continue to be billed until the balance is paid.

Payment Arrangements

Payment is expected at the time of service. Any balance due on your account must be paid prior to your visit and will be collected in addition to your co-pay. If you do not have your co-pay or payment for your outstanding balance at the time of service, your visit may be rescheduled. Should you ask us to bill your copay, a $10.00 service fee will be added. Payments on balances can be made online.

Delinquent Accounts

Bills that are delinquent for more than ninety (90) days will be transferred to an outside collection agency for processing unless prior arrangements have been made with our business office. If you have questions or reason to believe there is an error, please discuss them with us prior to the 90 days.

Returned Checks

There is a $25.00 service fee for checks returned for insufficient funds. We will not re-deposit checks and will no longer be able to accept checks for payment. The balance due + service fee must be paid with cash or credit card immediately upon notice of the returned check.

Cancellation of Appointments/No Show Appointments

If you need to cancel your appointment, we require 24 hour notice; if you do not cancel an appointment and no show, you will be charged a $50.00 service fee. Three no show appointments are grounds for dismissal from the office.

Advance Beneficiary Agreement

Medicare and other insurance plans will only pay for services that they determine to be reasonable and necessary under section 1862 (a) (1) of Medicare Law. If they deny payment for services or tests, (i.e. routine exam, testing, labs, vaccinations, injections, procedures, etc) then the patient agrees to be personally and fully responsible for payment.

In addition, I understand and acknowledge that for hormone replacement therapy or similar programs, Dr. Talluri has a small in house dispensing program where individualized custom medications can be dispensed directly to patients. I understand there is an extra cost associated for the service and convenience of these programs.

Additional Help

Please feel free to discuss any concerns you may have with our office staff. Our staff is dedicated to making your visits with us as pleasant as possible.
It is your responsibility to know what is covered by your insurance plan as well as being financially responsible for any services denied or not covered by your insurance.

I have read and agree to the above policy of Cholla Medical Group Primary Care. I understand the contents and by signing below accept the financial responsibilities listed above.

Patient/Legal Representative: ______________________________________ **Date:** ___________________________

ACKNOWLEDGEMENT OF RIGHT TO REVIEW CHOLLA MEDICAL GROUP PRIMARY CARE'S NOTICE OF PRIVACY PRACTICES

I understand I have a right to review Cholla Medical Group Primary Care's Notice of Privacy Practices prior to signing this document.

The Notice of Privacy Practices is available at the reception desk. Cholla Medical Group Primary Care reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I understand that I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail, or by requesting a revised copy at the time of my next appointment.

____

Signature of Patient or Personal Representative Date

____

Print Name of Patient or Personal Representative

____

Description of Personal Representative's Authority (i.e. Legal guardian, parent, attorney, etc.)

(over)

If you wish to request RESTRICTIONS or limitations on the use of your Protected Health Information, or to request confidential communications please let our receptionist know, so that the proper forms may be completed. Please indicate below if you **do not** want us to leave account information on your cell phone, answering system or your home answering machine.

____

Please list the names and relations of anyone you authorize to be involved in your care and payment and with whom we may share your medical information:

____

____

For Office Use Only:

Acknowledgement of receipt of Notice Of Privacy Practices was unable to be attained because:

____

____

Signature of Staff Member:____
Date:___________________

CHOLLA
MEDICAL GROUP, INC.

Cholla Medical Group, Inc.
Controlled Substance Agreement

I, ___________________________________ understand that in order to receive prescribed medications at **Cholla Medical Group, Inc.** (hereafter referred as **CMG)**, I agree to comply with the following:

A. **USE OF MEDICATIONS**: I will take all medications as prescribed. I will speak with a provider at **CMG** before making any change in either the dose or frequency of taking my medications. There will be no early refills of controlled substances due to self escalation of medications. Narcotic pain medications must all be obtained from the same pharmacy (any exceptions must be approved by **CMG**).

B. **SEEKING PRESCRIPTIONS**: I will neither seek nor fill controlled prescriptions for any medications including pain relief from any other health care provider unless authorized by **CMG**.

C. **MEDICAL RECORDS RELEASE:** I will inform all of my health care providers that I receive controlled prescriptions including pain management medication(s) through **CMG** and will maintain an unrestricted and current medical records release on file with **CMG**. I authorize **CMG** to provide a copy of this Controlled Substance Contract to release medical information to necessary pharmacies.

D. **DRUG SCREENING: I will participate in drug screening as a part of my treatment plan. I understand that drug screening will be conducted ongoing and may be required more frequently at the discretion of CMG. Screening may include urinalysis, blood testing and/or pill counts. I further understand that if I fail two (2) drug screens during the course of my treatment, it will result in discharge from the medical practice.**

E. **ALCOHOL USE:** Any use of alcohol with prescriptions is against clinic policy. Testing for alcohol use may be added to random and routine urine drug screens at the discretion of the physician. Any use of alcohol deemed inappropriate by the physician will be grounds for discharge from **CMG**.

F. **ILLEGAL AND NON-PRESCRIBED DRUG USE**: I understand that the use of any controlled medication, not prescribed by **CMG**, may result in termination of care. I authorize **CMG** to cooperate fully with any city, state, or federal law enforcement agency. I agree to waive any applicable privileged, right of privacy, or confidentiality with respect to these authorities.

G. **LOST OR STOLEN MEDICATION**: I agree to safeguard all medication prescribed by **CMG** and understand that **lost, stolen, or damaged medications will not be replaced.**

H. **PRESCRIPTIONS WHILE TRAVELING: CMG** may choose to provide prescriptions for up to 60 days when I am traveling out of state. I will only be eligible for early medication when proof of travel can be obtained. Identification includes paper tickets and electronic confirmation sheet that shows how much I paid for travel tickets. I will have to arrange for shipment of controlled substances by my pharmacy at my own expense. If I will be out of state longer than 60 days, I need to arrange for my healthcare at my travel destination. On my return to Arizona, I need to advise **CMG** of the name and address of my medical provider out of state. I also authorize **CMG** to contact my provider to obtain any detailed information deemed necessary of my medical care.

I. **DRIVING AND OPERATING EQUIPMENT**: Many controlled substances, including pain medications can cause drowsiness and/or a very relaxed state of mind causing operation of equipment or vehicles to be dangerous. I agree to refrain from driving or operating dangerous equipment for 72 hours after any change in medication dosage and whenever I feel drowsy.

J. **MISSED APPOINTMENTS**: I will contact the clinic if I will be 5 to 10 minutes late. If I arrive more than 15 minutes late, I will be rescheduled. Three missed appointments per year are grounds for discharge from **CMG**.

K. **CANCELLATIONS:** As of **January 1, 2021**; we require a 24 hour notice to cancel or reschedule your appointment. Appointments missed, rescheduled due to tardiness, or rescheduled without a 24 hour notice will result in a **$50.00** fee to the patient.

L. **CHARGES:** All fees from patients are due at the time of visit. Non-payment of fees may result in the account being sent to collections and patient termination from **CMG**

M. **TERMINATION**: I will no longer be eligible for care at **CMG** if I am in possession of illicit drugs or substances, trafficking of controlled or illegal substances, intoxicated or convicted for DUI. If I forge or alter the prescriptions in any way, sell or share medications, or fail to comply with this contract, I will no longer be eligible for care at **CMG**.

N. **TREATMENT OF STAFF: Our office has a zero tolerance policy for verbal abuse towards our staff. Swearing, yelling at, or threatening our staff will results in immediate termination of service from our office.**

O. **EMERGENCY ROOM VISITS:** I am allowed to receive controlled substances, including pain medication in the emergency room, but it is a violation of the **CMG** contract to receive narcotic medication to take home and it must be discussed with the on-call doctor prior to receiving medication. A violation includes any prescription and/or samples.

I HAVE THOROUGHLY READ THIS AGREEMENT BEFORE RECEIVING TREATMENT AT CMG. I UNDERSTAND AND AGREE TO THE CONDITIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM. ALL OF MY QUESTIONS ABOUT THE TERMS OF THIS AGREEMENT HAVE BEEN ANSWERED. I KNOW THAT FAILURE TO COMLPY WITH ANY OF THESE TERMS OF THIS AGREEMENT MAY RESULT IN IMMEDIATE TERMINATIONS OF SERVICE.

Patient's Signature: ____Date: ______________

Witness Signature: ____Date: ______________