VAULT AGREEMENT

Thank you for choosing Lisa R. Kroopf, MD as your physician. Providing you excellent care is our first priority. In order to offer you the best possible service, we are providing information regarding our financial and billing policies. Please read this information and sign below. Please ask our staff if you have any questions or concerns.

INSURANCE COVERAGE:

As a courtesy, we will bill your insurance carrier(s). We require that insurance cards be presented prior to/at the time of service so that we may verify coverage.

If your insurance carrier shows we are a participating provider, and/or we accept assignment of benefits, **all applicable co-pays, co-insurance, and deductibles are due at the time of service.** Please keep in mind that participating providers may change from time to time and it is the responsibility of the patient to verify whether or not the physician you are seeing is listed as a participating provider with your specific insurance carrier's network. If your physician is not a participating provider, you will be billed at "out of network" ("self-pay") rates.

Insurance coverage is an agreement between the patient and their insurance plan. It is your responsibility to remit payment for charges not covered by your insurance unless your carrier clearly states in writing that you are not responsible. If there is a question about whether or not your insurance will cover a specific service, we may ask you to sign a financial waiver before that service is provided.

A billing statement will be mailed to you after insurance claims have been processed. If you are unable to pay your complete balance upon receipt of the statement, it is your responsibility to set up a payment plan with our billing department. If we do not receive payment or communication from you about your remaining balance **within 30 days of the statement date**, we will charge the remaining balance to your credit card on file in our Vault.

Please note that if you decide not to keep a credit card on file in our Vault, you will be required to make a $50 deposit for each office visit. Payment is due at the time of making your appointment. Failure to cancel your appointment within 24 hours/one (1) business day will result in a $50 cancellation fee (forfeiture of your deposit).

NO INSURANCE COVERAGE/NO OUT OF NETWORK BENEFITS ("SELF-PAY"):

Payment is due on the day services are rendered. A list of our fee schedule for consultations and procedures is available to patients upon request.

If your insurance carrier shows we are not a participating provider, or if you do not have insurance, please be prepared to pay your bill in full at the time of service. If you request, we will courtesy bill your insurance carrier. In most cases, any reimbursement will be sent directly to you by your insurance carrier.

INSURANCE COVERAGE CHANGES

If your insurance coverage changes, please provide a copy of both the front and back of your new insurance card so we can update your record. Failure to inform us of your new insurance information in a timely manner may result in a denial of your claim by your insurance carrier. In this case, the patient may be responsible for 100% of the allowable charges.

MINORS

Minor Patients: The parent(s)/guardian(s) accompanying a minor is/are responsible for full payment.

SURGERIES/PROCEDURES

For scheduled surgeries or procedures, a $25 deposit will be collected to hold your procedure date. The deposit will be applied to any patient financial responsibility owed for the procedure. If the balance due is less than the deposit,

the remaining balance will be refunded to the patient after insurance payments have been collected. For failure to cancel within five (5) business days of the procedure date, a $50 cancellation fee (forfeiture of your deposit and additional charges) will be applicable.

AUTOMATIC PAYMENT POLICY

Lisa R Kroopf MD has an automatic payment policy. We require our patients to keep a credit or debit card on file in our Vault with Rectangle Health. With your consent, we will charge this card any balances due, including, but not limited to co-payments, co-insurances, and deductibles. Payment will be run on the morning of your appointment. If you “No show” or cancel your appointment with less than 24 hours notice/one (1) business day, a fee of $50 will be charged to your card less the amount of balances billed for the visit. This policy applies to in-office visits, telemedicine appointments, and procedure/surgery appointments.

The vault system we use through Rectangle Health is secure, encrypted, and HIPAA compliant. Once entered, only the last four (4) digits of your card are viewable. For charges over $100.00, you will be notified prior to processing payment.

By signing below: I authorize **Lisa R Kroopf MD** to keep my credit card information on file and to charge my card for the balance of charges not paid within 30 days of remittance of my billing statement, in addition to any additional fees, including the no show/cancellation fee of $50. For planned surgeries or procedures, I authorize **Lisa R Kroopf MD** to charge my card on file a $25 deposit to hold my procedure/surgery date, which will be forfeited if I No show/cancel with less than 5 business days notice.

I assign my insurance benefits to the Lisa R Kroopf MD listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

Circle one:

Master Card Visa American Express Discover Card

Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

exp: _____ / _____ CVV: __ __ __ Zip Code: _______________

Card Holder’s Name: ____

Patient’s Name (if different): ____

Signature: ____ Date: ____________________

I understand and agree to the above policy and I am the person responsible for payment of services rendered by Lisa R. Kroopf, MD, A Professional Medical Corporation.