

PHENIX MEDICAL MINISTRY (FINANCIAL POLICY)

Thank you for choosing Phenix Medical Ministry to serve our healthcare needs. We are committed to providing the highest quality care at the lowest possible cost. Prompt payment for services rendered helps to keep costs under control. Your understanding and support of our financial policy is essential.

PATIENT STATEMENTS

Patient statements are sent monthly & payment is due upon receipt. If you should have a question about your bill, please contact a Patient Accounting Representative, between 9:00am & 5:00pm., weekdays, by calling (334) 448-9505.

For the convenience of our patients, we accept cash, checks and /or credit (Visa and MasterCard) Payments may be made in person,. Between 9:00am & 5:00pm., weekdays, at the office or you may mail your payment payable to:

Phenix Medical Ministry
1700 21st CT Suite A
Phenix City, Al 36867

INSURED PATIENTS

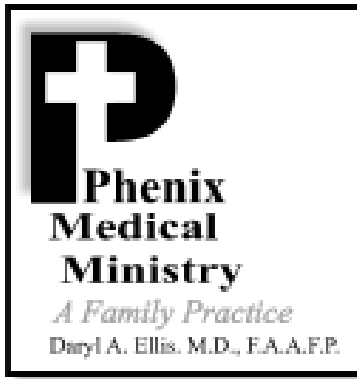
Insurance cards along with any pertinent insurance information should be presented at every visit. Your insurance policy is a contract between you and your insurance carrier. Phenix Medical Ministry is not a party to contact. **IT IS YOUR RESPONSIBILIY TO BE ARWARE OF YOUR HEALTH INSURANCE COMPANY'S RULES, REGULATIONS, RESTRICTIONS AND PAYMENT POLICIES.** Payment of co-payments, co-insurance, and/or deductibles is expected at time of service, prior to treatment. Most insurance plans will not cover routine exams (except preventative care), cosmetic surgeries, contraceptive drugs or devices, treatment of infertility or impotence, hormone replacement, certain eye surgeries, eye glasses or contact lens, eye refraction, etc..

In addition to several managed care contracts, Phenix Medical Ministry participates with Medicare & Medicaid. If Phenix Medical Ministry is contracted with your insurance carrier we will file your claim. Once your insurance carrier processes the claim, you will receive patient statement for the unpaid amount deemed patient responsibility by your insurance company. If you have a secondary carrier, we file the claim for the balance. If we are not contracted with your primary and/or secondary carrier, we will file the claim as courtesy. However, if the claim is not processed within 60 days we will send you a statement for the balance.

YOU ARE ULTIMATELY RESPONSIBLE FOR THE PAYMENT OF SERVICES RENDERED.

Caring For Families Like Family

1700 21st Ct. Suite A * Phenix City, Alabama 36867 * Office 334-448-9505 * Fax 334-448-9575



UNINSURED PATIENTS

If you have no insurance coverage, we ask for payment in full at time of service. If you cannot pay in full, please make arrangements in advance, prior to your appointment. Phenix Medical Ministry is under no obligation to extend credit, but may do so at its discretion. If credit is requested Phenix Medical Ministry will consider medical necessity, payment history, and ability to pay when making a determination. Accounts over 120 days without satisfactory payment will be turned over to a collection agency and reported to the credit bureaus. If your account is sent to collections, you may be terminated from service for non-payment and your account deactivated. If this were to happen, you would no longer be able to receive treatment from Phenix Medical Ministry. We encourage you to work with our business office to avoid this situation.

RETURNED CHECKS

Phenix Medical Ministry will charge \$40.00 or 5% of the face amount of the check, whichever is greater, on all returned or canceled checks. This fee is due & payable along with the face amount of the check within 10 days of notification. After 10 days, the matter may be reported to the magistrate for criminal prosecution.

QUOTES & ESTIMATES

Although Phenix Medical Ministry has an established fee schedule, it is difficult to provide complete and accurate quotes for all services and /or procedures prior to treatment. Fees quoted prior to treatment are provided as estimates only any actual charges may vary.

PHENIX MEDICAL MINISTRY

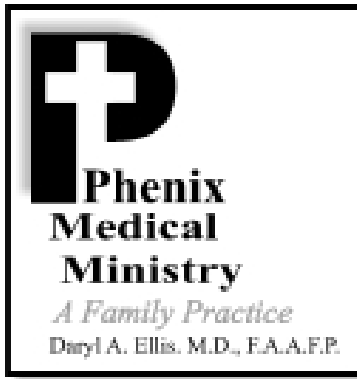
1700 21st CT. SUITE A
PHENIX CITY, AL 36867
PHONE: 334-448-9505
FAX: 334-297-2441

I fully understand and accept the terms of the Phenix Medical Ministry financial agreement.

Patient's Signature _____

Date: _____

Caring For Families Like Family



PHENIX MEDICAL MINISTRY NO-SHOW POLICY

EFFECTIVE APRIL 1, 2004 DUE TO INCREASES IN MISSED APPOINTMENTS, THE NEW NO-SHOW POLICY READS AS FOLLOWS.

* PATIENTS THAT MISS 3 CONSECUTIVE APPOINTMENTS WITHOUT CALLING TO CANCEL PRIOR TO VISIT WILL BE DISMISSED FROM THE PRACTICE.

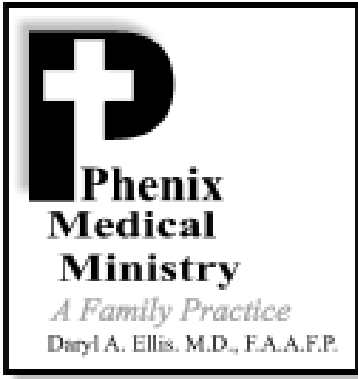
* PATIENTS THAT MISS 3 APPOINTMENTS AT ANY GIVEN TIME WITHOUT CALLING TO CANCEL PRIOR TO APPOINTMENT TIME WILL BE SERVICED CHARGED \$25.00 FOR EVERY MISSED APPOINTMENT THERE AFTER. THE DECISION TO DISMISS PATIENT FROM THE PRACTICE WILL BE AT THE PROVIDERS DISCRETION.

I fully understand and accept the terms of the Phenix Medical Ministry No-Show Policy.

Patient's Signature _____

Date: _____

Caring For Families Like Family



TO: All Patients

FROM: Daryl A. Ellis, MD
Medical Director, Phenix Medical Ministry

RE: After hours care

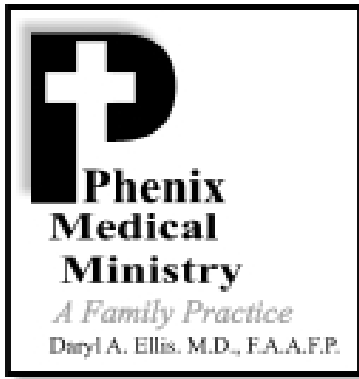
If for any reason, you require medical care after normal operating hours, you are directed to go directly to the nearest Emergency Department for medical evaluation. Once that evaluation has been done, and initial treatment given, we will welcome you to the office on the following business day for re-evaluation and continuing care.

I _____, have read and understand the after hours policy of Phenix Medical Ministry.

Patient Signature _____ Date Signed _____

Witness Signature _____ Date Signed _____

Caring For Families Like Family



Phenix Medical Ministry Daryl Ellis M.D.

CONSENT FOR TREATMENT

I give my consent for Phenix Medical Ministry and its physician, physicians assistant, nurse practitioner, nurses, technicians and other health care providers to perform the examinations, test and/or treatments that are ordered by my physician and are appropriate to the nature of my condition(s). I understand that the results from all such examinations and test are confidential. Before the contents of my medical record are released or shared, other than by subpoena, court order, or statute, this office is required to have my written consent. This written consent for will state exactly to whom the record will be released, which protion of the medical record will be released, and for what purpose will the information be used. _____ Initial

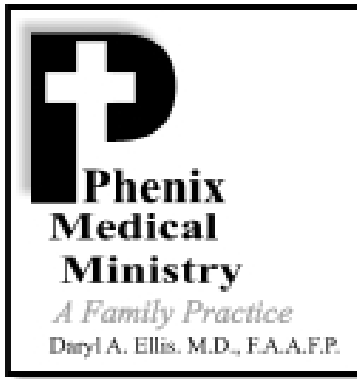
REFUSAL OF TREATMENT

The procedure ordered has been explained to be medically necessary for treatment. At this time I am refusing to have it done. _____ Initial

Patient's Signature

Date

Patient's Legal Agent



Phenix Medical Ministry Patient Record of Disclosures

In general the HIPPPA privacy rule gives individual the right to request confidential a restriction on uses of their protected information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's home.

I wish to be contacted in the following manner (check all that apply):

_____ Home telephone _____

_____ O.K. to leave message with detailed information

_____ Leave message with call-back number only written Communication

_____ O.K. to mail to my home address

_____ O.K to mail to work/office address

_____ O.K to fax this number. _____

Work telephone _____ Other _____

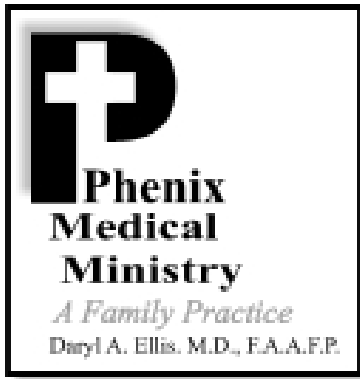
_____ O.K. to leave message with detailed information _____

_____ Leave message with call-back number only _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.



**New Patient Consent to the use and Disclosure of Health Information
for Treatment, Payment, or Health care Operations**

I, _____, understand that as part of my health care, Phenix Medical Ministry originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

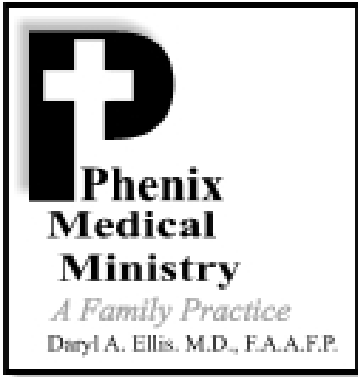
I understand and have been provided with *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Phenix Medical Ministry is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Phenix Medical Ministry reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Phenix Medical Ministry change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:



I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

Patient's Signature

Date

FOR OFFICE USE ONLY

- Consent received by _____ on _____.
- Consent refused by patient, and treatment refused as permitted.
- Consent added to the patient's medical record on _____.