Kick Some Mass, LLC
Dr. Jeffrey A. Ruterbusch

FINANCIAL POLICY

As your physician, I am committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Kick Some Mass. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED

We accept cash, personal checks, Visa, MasterCard, American Express, and Discover.
Returned checks are subject to a $35.00 service fee and you will lose your privilege to write checks in our facility. We will not accept post-dated checks and we will not hold checks until a later date for deposit.

PERSONAL INFORMATION CHANGES

I will make the front office personnel of Kick Some Mass aware of any changes in personal information i.e. change of address, marital status, new phone numbers, new emergency contact, etc.

HMO/PPO INSURANCE COVERAGE

I understand services at Kick Some Mass, LLC may be reimbursable by my insurance carrier, however Kick Some Mass does not participate in insurance plans and is considered out of network. I will have the option to be a self-pay patient and therefore financially responsible for the total amount of the services provided. I understand that I will be responsible for prompt payment of all amounts owed to Kick Some Mass upon completion of each visit.

MEDICARE

I under that Kick Some Mass does participate in Medicare, however there is no guarantee that services will be covered 100%. In the event services are not covered, I understand I will be responsible for any balance not paid by Medicare.

LABORATORY BILLING PROCEDURE

I have been informed that all laboratory procedures done outside of the office will not be included in the charges for Kick Some Mas. All lab tests performed by an outside laboratory are billed separately to either my insurance company or myself. I understand that all charges not covered by my insurance are my responsibility. I will

direct any questions regarding a bill or statement from an outside laboratory to the lab.

NO SHOW POLICY (Please initial)

____ There will be a $75.00 charge if you fail to show for your scheduled office appointment with Dr. Ruterbusch and $35.00 charge for nutritional counseling or personal training. It is your responsibility to notify the office 24 hours in advance if you are unable to keep your office appointment.

CONSENT FOR MEDICAL TREATMENT

~~I am the patient, or the patient's duly authorized~~ representative, and do hereby voluntarily consent to and authorize care encompassing the performance of all appropriate procedures and courses of treatment, the administration of all supplements, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations performed. This form has been fully explained to me and I certify that I understand and accept its contents as noted.

PRIVACY POLICY

I have received a copy of Kick Some Mass privacy policy and have been give the opportunity to have my questions, if any, answered.

FINANCIAL AGREEMENT

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your financial responsibility.

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We are do provide billing in our office, however we cannot guarantee payment.

- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.**

Collection action will be taken for any charges older than 90 days. We realize that emergencies do arise that may affect timely payment of your account. If extreme circumstances occur, please contact us promptly for assistance in the management of your account.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date: _____

Patient Signature: _____

Printed Name of Patient: _____

Parent, Guardian or Legal Representative Signature: _____

Printed Name of Parent, Guardian or Legal Representative: _____

Relationship to Patient: _____

Legal Representative's Authority to Act for Patient (Power of Attorney, Healthcare Surrogate): _____

Revised 11/2016