NOTICE OF FINANCIAL POLICY SUMMARY & AGREEMENT

Thank you for choosing Renaissance Medical Group.
We are committed to providing quality care and clear communication about your financial responsibilities. Please review the summary below and sign at the bottom.

KEY FINANCIAL POLICIES

Payments:
All copays, deductibles, and balances are due at check-in unless prior arrangements are made.

Accepted Payments:
We accept cash, check, VISA, MasterCard, and AMEX. Returned checks may incur a $35 fee.

Insurance:
We will bill your primary insurance as a courtesy. You must provide current insurance info and notify us of changes. You are responsible for any unpaid portion.

Referrals/Authorizations:
If your plan requires a referral or pre-authorization, you must obtain it prior to your visit. Without it, your appointment may be rescheduled and charges may become your responsibility.

Out-of-Network/No Insurance:
If we are not in your insurance network or you are uninsured, payment is due at the time of service. Self-pay patients must make arrangements in advance.

Billing & Collections:
You will receive up to 2 statements. If unpaid after 90 days, your account may be sent to collections. Collection costs are your responsibility.

Missed Appointments:
A $50 fee applies for missed appointments without 24-hour notice.

Forms & Records:

- Form completion (e.g., FMLA): $50 per form, allow 5 business days.
- Patient medical records: No charge.
- Attorney/insurance record requests: Fees apply based on page count and request type.

Workers' Comp & Third-Party Claims:
We do **not** accept workers' compensation or bill third-party insurers (e.g., auto). You must pay in full and seek reimbursement.

Hardship:
If you're experiencing financial hardship, speak with our billing staff about possible payment plans. Proof of hardship may be required.

ACKNOWLEDGMENT & AGREEMENT

I have read, understand, and agree to the above Financial Policy. I accept full responsibility for any charges not covered by my insurance.

Signature of Patient	Date of Birth
Patient Name	Date

HIPAA NOTICE OF PRIVACY PRACTICES – PATIENT ACKNOWLEDGMENT FORM

This summary explains how your health information may be used and shared. Please read and sign below.

Our Responsibilities:

- We are required by law to protect your health information.
- We may update this notice and will inform you of any changes.
- You will be notified if your health information is breached.

How We Use and Share Your Information

We may use and disclose your information for:

- Treatment – To provide and coordinate your care.
- Payment – For billing and insurance purposes.
- Health Care Operations – For administrative, quality improvement, and compliance efforts.
- Family/Caregivers – When involved in your care or during emergencies.
- Business Associates – Outside vendors who help us operate (e.g., billing, legal).\
- Appointments & Services – To contact you regarding care or services
- Research/Fundraising – With privacy safeguards or your permission.

Uses Requiring Written Authorization

We must get your written permission to use or share:

- Psychotherapy notes (with limited exceptions)
- Genetic information
- Information for marketing purposes
- Information for sale (with few exceptions)

Your Rights

You have the right to:

- Access and get a copy of your medical records
- Request corrections to your health information
- Request limits on how we use or share your information
- Ask for a list of disclosures we have made
- Receive confidential communication in the way you prefer
- Get a paper copy of this notice
- Be informed of any data breach
- File a complaint without fear of retaliation

Questions or Complaints?

Contact our **Office at renaissancemedicalgroup05@gmail.com | (725) 310-7859**
Or contact the **U.S. Department of Health and Human Services:**

Office for Civil Rights
Department of HHS
Jacob Javits Federal Building
26 Federal Plaza, Suite 3312, New York, NY 10278
Phone: (212) 264-3313 | Fax: (212) 264-3039