Capitol Hill Medical is committed to your health and to the health of the LGBTQ community. We strive to provide quality, evidence-based care in a personalized supportive manner. We are a small, independent clinic, and we want to stay this way to continue to provide outstanding care for years to come. You might notice there aren’t a lot of us left in small practices that aren’t concierge practices. That is because the current financial environment of the healthcare system favors large conglomerates.

In order to ensure we can continue to provide outstanding care for years to come, we need to make sure our patients understand and can agree to our financial policies.

**Health Insurance Benefits:** Health insurance can be confusing. It is the patient’s responsibility to understand their deductibles, coinsurances, copays, and benefits. Call your insurance to confirm your plan will allow you to come to Capitol Hill Medical and doesn’t restrict you to specific organizations. You will be responsible for all fees incurred in your care that your health insurance doesn’t cover.

**Copays:** All copays are due at the time of service. We take all major credit cards, checks, and cash.

**Arriving Late/Cancellations:** Our providers will try our best to respect your time and avoid keeping you waiting if at all possible. To assist them, we ask that you arrive at least 15 min early for new patient appointments, and at least 5 min early for existing patient appointments. Late arrivals will cause the provider to run behind and will impact many more patient appointments. If you are more than 5 minutes late for your appointment, you will need to reschedule. If you can’t make your appointment, please give us at least 24 hours notice so that we can offer your appointment time to another patient. If you fail to give us 24 hours notice, you will be charged a $50 fee. If you fail to give 24 hours notice repeatedly, we will ask you to seek care elsewhere. Reschedules due to arriving late will be marked as a no show, and you may be charged the no show fee.

**Forms and Paperwork:** We charge $25 for forms and paperwork completed outside of a medical visit.

**Medicaid:** We are currently capped on the number of patients we are able to accept with Medicaid plans including Apple Health, United Community, and Medicaid Molina plans. If you switch to a Medicaid plan, please let us know ASAP so that we can give you recommendations for finding another provider.

**Auto and Work Injuries:** Unfortunately, we are not set up to bill for auto or work injuries at this time. Should you need care for an injury or illness caused through work or through a motor vehicle accident, you will need to seek care elsewhere for those instances. You can go to an emergency room or urgent care center or you can call Sound Providers Group (206-402-7106) or Washington Physicians Referral Network (206-745-2013), and they will set you up with a provider that does bill for auto and work injuries.

**Outstanding Balance:** We ask that you pay your balance promptly. You can now pay through the patient portal. Failure to pay any balance after three statements have been sent will result in the forwarding of the balance to a collection agency, and you will not be able to return to the clinic until the
balances are paid in full. If you cannot pay your balance, please call our billing department to discuss a payment plan (Medical Billing Solutions – Tara 206-431-0138 ext. 1007).

Labs: We typically send out bloodwork and other labs to LabCorp. LabCorp will then bill your insurance, and you will be responsible for any charges your insurance doesn’t cover. We draw your blood to send to the lab as a courtesy to save you time, but we are not privy to the charges as they are determined by the contract your insurance has with LabCorp. For all lab billing inquiries, please contact LabCorp directly. If you prefer to use another lab, please be sure to tell us at the time of your visit.

Preventative Visits: Most insurance plans will cover, in full, one preventative annual exam per 365 days. If a problem is also addressed during this preventative visit, copays, coinsurances, and deductibles may apply.

Please sign and date the following financial agreement:

1. PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION:
   I hereby authorize and direct payment of my medical benefits to Capitol Hill Medical, PLLC for any services furnished to me by the medical providers. I authorize the medical provider to release any information, including diagnosis and the records of any treatment or examination rendered to me during the period of such medical services to third party payers and/or health practitioners. In the event that my health plan determines a service to be “non-covered”, I will be responsible for the complete charges. I agree to be responsible for payment of all unpaid services on my behalf that are not deemed contractual adjustments by my private insurance.

2. AUTHORIZATION OF PAYMENTS:
   I understand that Capitol Hill Medical, PLLC will submit my medical claim to my insurance carrier. I hereby authorize payment directly to Capitol Hill Medical, PLLC and its providers of medical benefits, otherwise payable to me, for the services provided. I understand that I am financially responsible for my health insurance deductibles, coinsurances, and copays unless a secondary or tertiary insurance is involved. I understand that I am responsible for non-covered services by my health insurance plan(s).

3. ADDITIONAL SERVICES:
   I understand that outside laboratory services may be used in my standard of care. I understand that I am responsible for any health insurance deductibles, coinsurances, copays, and non-covered services, and will work directly with said companies regarding payment or conflict resolution.

4. AGREE TO CAPITOL HILL MEDICAL, PLLC FINANCIAL POLICIES:
   I have read, understand, and agree to abide by the financial polices detailed out in this document.

Print Name: ________________________________

Signature of Patient (or Responsible Party) ________________________________ Date ________________________________