Coral Patient Financial Responsibility Agreement

Please read and sign where indicated – this document describes your financial responsibilities and authorizes Coral to transmit your information to healthcare providers and Christian Healthcare Ministry. You are being granted access to healthcare facilities and providers who have contracted with Coral because you are a member in good standing of Christian Healthcare Ministry.

CHM Member Name: _____

CHM Member No.: _____

Incident Description: _____

This is a legally binding contract between Coral LLC and you. The words, I, me, my, you and your all refer to the patient or undersigned responsible member.

- I agree to be financially responsible for payment of healthcare services delivered by healthcare facilities and providers contracted with Coral to whom I have been referred by Coral. Cash, check or credit cards are acceptable forms of payment for these services.
- I understand and agree that payments must be received 5 days prior to the scheduled healthcare service appointment, or the appointment will be automatically canceled. In the event the healthcare service appointment is canceled 24 hours prior to the scheduled time by the patient, or canceled by the facility or provider, the funds will be returned less any fees for ACH transfer within 10 business days of a request, and after 30 days if there is no request and no confirmed rescheduling of the healthcare service.
- I understand and agree, as a Member of Christian Healthcare Ministry (CHM), that my request for healthcare services through Coral is automatically submitted to CHM for review. By signing this Agreement, I authorize CHM to remit all sharing payments for this incident to Coral on my behalf. I further understand and agree that I remain responsible for paying any difference between remitted CHM sharing amounts and the Coral pre-funding Invoice.
- I agree to present a Coral voucher confirming pre-payment at every office visit or at check-in for a scheduled procedure.
- I understand that I will be responsible for any missed appointments or any cancelled appointments in which I am able to, but do not, give a 24-hour notice of cancellation. I agree to pay a fee of $250.00 for any missed consultation visits and any missed office procedures. I further agree to pay a fee of $750 for missed outpatient procedures and $1,500 for missed in-patient procedures.
- I agree to pay a $55.00 fee for all returned Checks.
- I understand that all services provided to me by facilities and providers accessed through Coral are considered medically necessary. I further understand that if I fail to have a

procedure performed or do not comply with my provider's instructions this is likely against medical advice and may mean the procedure cost is not sharable. Should this occur, I agree to pay any balances due.

- I agree that if my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I agree to be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.
- Medical Information

I understand that as part of my health and medical care Coral and Facilities and Providers contracted with Coral, originate and maintain medical and health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I further understand that this information serves as:

i. a basis for planning my care and treatment;

ii. a means of communications among the health professionals who contribute to my care;

iii. a source of information for applying my diagnosis and treatment information to my bill;

iv. a means for a third-party payer to verify that services were billed as actually provided; and

v. a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and agree that this information may be released to all of the above-described persons and firms who have a need to access this information, and I further agree that this authorization to release information shall apply to all information accumulated up to this date and to any information acquired in the future pertaining to this specific incident.

I have read and I understand the above policies and I accept responsibility for the payment of all fees and costs associated with my care, or the care of a person for whom I am responsible.

Patient Signature _____ Date _____

or

Responsible Party Signature _____ Date _____