Sally Kraynik NP LLC: Patient Financial Responsibility Agreement

Sally Kraynik NP LLC ("**Group**") is committed to providing the best quality healthcare services (the "**Services**"). This Patient Financial Responsibility Agreement ("**Agreement**") outlines your financial responsibility in relation to receipt of the Services from Group. Group participates in certain insurance and health plans, including Medicaid, Medicare, and Commercial insurance. Please let Group know if you have medical insurance that you plan to use for payment of the Services.

Insurance
To the extent you have insurance that is accepted by Group, you understand, acknowledge, and agree to the following:

- **FOR EXCEPTIONS TO THE FOLLOWING, please refer to the Sliding Fee Discount Program designed to provide free or discounted care to those who have no means, or limited means, to pay for their medical services (uninsured or underinsured).**

- My medical insurance policy, if any, is a contract between me and my insurance company. It is my responsibility to know my benefits, and how they will apply to payment for the Services provided by Group.

- It is my responsibility to confirm that the provider that I see at Group is a participating provider under my medical insurance policy.

- My insurance company may not cover 100% of the costs and fees associated with the Services provided by Group. I agree to be responsible for full payment of any remaining balance due for the Services, including without limitation, for paying co-payments, coinsurance, deductibles, and any other costs and fees associated with the Services I receive that are not fully (or at all) covered by my insurance company, as discussed below under Self-Payment of Services.

- It is my responsibility to provide Group with appropriate and current medical insurance information, and to notify Group immediately upon any change in my medical insurance coverage to ensure efficient claims billing and payment. In the event that I fail to provide all necessary and current medical insurance information, I understand that my insurance company may deny payment of claims relating to the Services, and I understand that I may be 100% responsible of the costs and fees associated with the Services.

- It is my responsibility to have obtained any and all necessary referrals and authorizations required prior to receiving the Services from Group. If my insurance company requires a referral and I do not have one, then I understand that I will be responsible for all cost and fees associated with the Services I receive.

- If my medical insurance requires a co-pay, the co-pay is due at the time noted on any invoice.

- **IF I HAVE ANY HEALTH INSURANCE, to qualify for the Sliding Fee Discount Program, I must agree to insurance billing. If I have insurance but request that the Service not be submitted to my medical insurance, I will not be eligible for the Sliding Fee Discount Program.**

Assignment of Benefits

To the extent you have insurance, you further understand, acknowledge, and agree to the following:

- I hereby assign to Group all my right, title, and interest in any and all health insurance or other health care benefits payable to me or on my behalf by any insurance payer, including Medicare, private insurance and any other health plan for medical treatment rendered by Group.

- This assignment of benefits fully and completely encompasses any and all rights and legal claims I may have under any applicable plan or policy of insurance, the Employee Retirement Income Security Act, or otherwise, to receive benefits. These legal rights and legal claims include, but are not limited to: (i) my rights to make a claim for and/or appeal any denial of benefits on my behalf; (ii) my rights to pursue legal action against the applicable third-party payer for unpaid benefits or for violating any contractual, statutory, legal, or equitable duties to me, including, but not limited to, any and all claims I may have for unpaid benefits, breach of contract, breach of covenant of good faith and fair dealing, breach of fiduciary duty, denial of a full and fair review, quantum meruit, unjust enrichment, or promissory estoppel; and (iv) my rights to file a complaint with any applicable federal or state agency against any third-party responsible for providing benefits.

- I hereby appoint Group as my authorized representative(s) to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible payer or third party liability carrier of any and all benefits due to me for the payment of charges associated with Services provided by Group. I agree that the insurer or plan's payment to Group pursuant to this authorization shall discharge its obligations to the extent of such payment.

- I hereby acknowledge the assignment will remain in effect until revoked by me in writing.

- I authorize the release of pertinent information necessary to process my medical claim. I also authorize direct payment to Group of all insurance benefits payable to me for such medical treatment. In the event an insurance payer pays me directly, I agree to immediately pay such amounts to Group.

Self-Payment of Services

To the extent the Services provided by Group are: (i) not covered by your medical insurance, (ii) Group does not accept your medical insurance (i.e., Group is out-of-network), (iii) you do not have insurance, or (iv) you have insurance but request that the Service not be submitted to your medical insurance, you understand, acknowledge, and agree to the following:

- **FOR EXCEPTIONS TO THE FOLLOWING, please refer to the Sliding Fee Discount Program designed to provide free or discounted care to those who have no means, or limited means, to pay for their medical services (uninsured or underinsured).**

- I am electing to purchase the Services from Group on a self-pay basis.

- ***Even if I have health insurance, I understand there is no guarantee my insurance company will make any payment on the costs and fees of the Services I have requested.***

- My insurance company, including Medicare, does not pay for everything and may pay less than the actual bill for the Services.

- I am 100% responsible for paying Group for any and all amounts not paid by my insurance company, including without limitation, payment for noncovered charges and copayments,

coinsurance, deductibles, and any other costs and fees associated with the Services that I receive that are not covered by my insurance company.

- In the event any collection action is necessary to collect amounts I owe to Group, I agree to pay all expenses associated with such action.

- Group has provided me with the charges, in advance, for the Services I have requested. The Visit Fee Schedule for telemedicine visits and Patient Portal Messages, etc. are kept up to date on Group website: https://www.sallykrayniknpllc.com/faq

- By signing below, I agree to pay these charges in full as a self-pay patient and agree to be 100% responsible for full payment of the listed price of the Services.

- **IF I HAVE ANY HEALTH INSURANCE, to qualify for the Sliding Fee Discount Program, I must agree to insurance billing. If I have insurance but request that the Service not be submitted to my medical insurance, I will not be eligible for the Sliding Fee Discount Program.**

By accepting, I understand, acknowledge, and agree to the terms of this **Patient Financial Responsibility Agreement.**

REVISED: 12/20/2025
REVIEWED BY: Sally Kraynik, NP