PATIENT FINANCIAL POLICY ADDENDUM

John P. Muffoletto, M.D., P.C.
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(907)276-1046

WE ARE NOT A CONTRACTED PROVIDER WITH ANY CHRISTIAN HEALTH MINISTRY CO-OP

1. Full payment is due at the time of service for initial consultation, established patient visits or surgery. As a courtesy we will gladly bill your Christian Health Ministry Co-op ("Co-op"). In the event the Co-op pays a portion of the visit we will issue a refund to you for the portion that is covered. Please refer to the full Patient Financial Policy for details regarding acceptable payment methods.

2. Your Co-op plan is a contract between you and your Co-op; it is not a contract between the Co-op and Dr. Muffoletto or John P. Muffoletto, M.D., P.C. (jointly the "Provider"). As a courtesy to you, Provider will file claims with your Co-op if you assign benefits to Provider, i.e. if you agree to have your Co-op pay Provider directly for his services. *If your Co-op does not pay the Provider within **45 days,** the Provider will look to you for full payment.*

3. As a non-contracted provider, Provider does not adjust his rates or accept any suggested write-offs from a Co-op, regardless of any preprinted information on your Co-op membership card. Any portion of any office visit or surgery that the Co-op does not cover is ***the patient's responsibility for payment.*** Please be advised that the Provider's deposit of a partial payment from a Co-op does not constitute satisfaction of all charges billed. Provider explicitly retains and reserves all rights to balance bill. Please refer to the full Patient Financial Policy for details regarding acceptable payment methods and minimum monthly payment requirements.

I have read and understand the above financial policy addendum as it relates to my financial responsibilities as a member of a Christian health ministry co-op and I agree to be bound by its terms. I understand and agree that such terms may be amended from time to time by the Provider. I specifically agree to be financially responsible for "non-covered" or "non-shared" services and any balances not paid by the Co-op.

_____ _____

Signature of Patient or Responsible Party (If patient is a minor)

Date

_____

Patient's Printed Name