FINANCIAL AGREEMENT

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Please read the information below carefully and if you have any questions or concerns, our staff would be delighted to address them. A copy of the agreement may be provided to the patient upon request.

Insurance: We participate in most insurance plans including Medicare and Medicaid. If you are not insured by a plan we do business with, you are responsible for the full payment of your visit. However, we do offer payment plans and you may speak to a staff member to enroll. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. Please make sure that you speak to your insurance representative if you need to change your PCP, prior to your visit.

Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your share at each visit. Contracted rates for each physician visit can differ. The pricing for two most common office visits are listed below.

1) New Patient visit / physical: $100 towards deductible + Co-pay

2) Follow up/ Nurse visits / blood draw visits: $50 towards deductible + Co-pay

Non-covered services: Please be aware that some – and perhaps all – of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for full payment of services rendered here that weren't covered by your insurance plan.

Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. We would be informed of your balance for the visit more accurately *after* we file your claim and receive an Explanation of Benefits from

your carrier. However, your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. I f your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Missed appointments. Our policy is to charge for missed appointments, a $50.00 fee, not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Please understand that we have technicians and specialists come into our office from other premises to make it more convenient for our patients to get the treatment they need. When you miss such appointments everyone, including you, suffers a loss. Therefore, we have a very strict no-show policy for all appointments that are missed without notice or not cancelled 24 hours prior to the appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Patient's Name (Print) Patient's Signature