FINANCIAL POLICY

As your physician, I am committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

FINANCIAL RESPONSIBILITY
I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Family Medical Centers. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED
We accept cash, personal checks, MasterCard and Visa. Returned checks are subject to a $40.00 service fee and you will lose your privilege to write checks in all our centers. Family Medical Centers currently uses Check Velocity, a returned check company who will automatically debit your account for the amount of the returned check plus the applicable service fee.

HMO/PPO INSURANCE COVERAGE
CO-PAYMENT AND DEDUCTIBLE MUST BE PAID AT THE TIME OF SERVICE. I understand that it is my responsibility to provide Family Medical Centers with a copy of my current insurance card and, if required by my insurance, to obtain a referral from my primary care physician. Family Medical Centers is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a self-pay patient and I am financially responsible for the total amount of the services provided. I will notify Family Medical Centers immediately upon any change to my insurance. We will file your insurance if we are under contract with your insurance company. I understand that all charges not covered by my insurance are my responsibility. If the insurance company fails to pay Family Medical Centers in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Family Medical Centers.

MEDICARE
Your deductible and 20% of the allowable charges are due at the time of service; however, since we are Medicare providers we will file your Medicare. I hereby authorize and assign all payments of authorized Medicare benefits for medical services and/or procedures rendered to patient, directly to Family Medical Centers. I hereby authorize Family Medical Centers to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by Medicare for which I have signed an Advance Beneficiary Notice ("ABN"). If we do not know the allowable charge for a specific service, you will be billed after payment is received from Medicare. Please bring your Medicare Explanation of Benefits to show that you have met your deductible for the year.

WORKER'S COMPENSATION
We will call your employer to authorize your visit prior to your appointment. We will file with your company's insurance.

AUTOMOBILE ACCIDENTS
We will file your insurance claim when you are involved in an automobile accident; however, it is your responsibility to provide us with your insurance information so that we can verify your coverage. You will be responsible for payment of your portion at the time you receive medical treatment.

LABORATORY BILLING PROCEDURE
I have been informed that all laboratory procedures done outside of the office (blood work, cultures, pap smears, urine drug screenings, etc.) will not be included in the charges for Family Medical Centers. All lab tests performed by an outside laboratory are billed separately to either my insurance company or myself. I understand that all charges not covered by my insurance are my responsibility. I will direct any questions regarding a bill or statement from an outside laboratory to the lab. Family Medical Centers will send my lab specimens to a laboratory that accepts my insurance. All lab screenings will be sent to Coastal Laboratories who is affiliated with Coastal Spine and Pain Center unless your insurance requires it to go to another lab (ie. Quest or LabCorp.)

NO SHOW POLICY (Please initial)
____ There will be a $50.00 charge if you fail to show for your scheduled office appointment. It is your responsibility to notify the office 24 hours in advance if you are unable to keep your office appointment.

____ There will be a $75.00 charge if you fail to show for your scheduled procedure appointment. It is your responsibility to notify the office 24 hours in advance if you are unable to keep your procedure appointment.

CONSENT FOR MEDICAL TREATMENT

I am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize care encompassing the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations performed. This form has been fully explained to me and I certify that I understand and accept its contents as noted.

CHILDREN OF DIVORCED PARENTS

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED, NO MATTER WHO IS RESPONSIBLE BY ORDER OF THE DIVORCE DECREE.

FORM COMPLETION FEE

Due to the large volume of forms that we are required to complete, our office reserves the right to charge up to $25.00 per page for the completion of forms. Dictated letters are dealt with on a case-by-case basis.

PRIVACY POLICY

I have received a copy of Family Medical Centers' privacy policy and have been given the opportunity to have my questions, if any, answered.

FINANCIAL AGREEMENT

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (e.g. yearly physicals and mole removals).

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company.

ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.

Collection action will be taken for any charges, including those that insurance has not paid, older than 90 days. We realize that emergencies do arise that may affect timely payment of your account. If extreme circumstances occur, please contact us promptly for assistance in the management of your account.

I do hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to Physicians Group Services, P.A. d/b/a Family Medical Centers. In the event I receive payment directly from my insurance company for services rendered by Family Medical Centers, I agree to endorse any check received to Family Medical Centers.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date: _____

Patient Signature: _____

Printed Name of Patient: _____

Parent, Guardian or Legal Representative Signature: _____

Printed Name of Parent, Guardian or Legal Representative: _____

Relationship to Patient: _____

Legal Representative's Authority to Act for Patient (Power of Attorney, Healthcare Surrogate): _____