

## PATIENT FINANCIAL AGREEMENT

Please read the following information carefully. When you sign this agreement and/or accept services from Falls Family Practice, Inc., you, the undersigned patient or responsible person, will be bound by the following terms. This will constitute an agreement between you and Falls Family Practice, Inc. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. Please understand, however, that you are responsible for payment for services, not your insurance company.

Payment for services is due at the time the services are rendered unless payment arrangements have been made in writing. We accept local checks, Mastercard or Visa. Returned checks will be subject to a \$25.00 fee. Balances that are due over 30 days will be subject to additional interest charges of 1-1/2% per month. Balances that are due over 90 days for which there are no mutually agreed upon payment plan will automatically be turned over for collection with charges for registered mailings, court costs, office expenses, personnel expenses, attorney fees, and other legal fees and costs added to the outstanding balance.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract or agreement between you, your employer, and the insurance company. We are not a party to that contract or agreement. In most cases a deductible or co-payment is involved that must be paid by you directly to the health care provider. In addition, not all services provided to you are covered by your insurance. Some insurance companies arbitrarily select certain services they will not cover. You are responsible for all services not covered by your insurance. If the insurance carrier does not remit payment within 60 days of service, you will be responsible for paying the balance in full.

We must emphasize that as a health care provider this agreement and our relationship is with you and not with your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above terms or any uncertainty regarding insurance coverage, please ask us. This is the entire financial agreement between us and shall be binding on the parties and their successors or assigns. Any changes must be agreed to in writing signed by both of us. The waiver of any term under this agreement shall not act as a complete waiver. If any term of this agreement is invalid or unenforceable under any law, the remainder will still remain in force.

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. By signing below I acknowledge that I have read this agreement and understand its terms. I further agree to be bound by this agreement.

PATIENT NAME (print) \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Person Responsible for Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Person Responsible for Patient

\_\_\_\_\_  
Relationship