



#### Attachment 4: **Financial Agreement Form**

Thank you for choosing the Practice of Coastal Pines Medical Group. We are committed to providing high quality, compassionate care. We ask all patients to review and sign this agreement. Please, ask any questions regarding the financial terms before signing.

**1. Assignment of benefits:** In consideration of the services rendered and to be rendered, I irrevocably assign and transfer to the above practitioner(s) indicated above, all right, title and interest in all benefits payable for the health care rendered, which are provided in any and all insurance policies, employee benefit plans, and/or third party actions against any other person or entity from whom my dependents or I are entitled to recover (hereinafter referred to as “benefits”). Said irrevocable assignment and transfer shall be for the purpose of granting the physician and independent right of recovery against such responsible parties, but shall not be construed to be an obligation of the physician to pursue any such right to recover. I hereby authorize all responsible parties to pay directly to the physician all benefits and amount due for services rendered by the physician. I understand that if the physician is not paid in full by proceeds for any benefits, then this assignment does not release my obligation and liability to the physician for payment and all services and items provided to me or by my insurance company or health benefit plan, then I agree to pay physician for all charges in excess of the benefits paid.

The terms and consequences of these irrevocable assignments and financial responsibilities have been fully explained to me to my understanding and I have signed this document freely and without inducement other than the rendition of services by the physician.

**2. Registration:** Our ability to bill for services is dependent on accurate information at the time of registration. We require a copy of a driver’s license, insurance cards, and

completed registration form with correct demographics to complete billing. If any of this information changes, it is your responsibility to alert us before a billable event occurs. We accept assignments and participate in many insurance plans. If your insurance is not a plan we participate in, payment is expected after each visit. Knowing your insurance benefits (e.g. deductible, copay) is your responsibility. To check for coverage, please contact your insurance company.

**3. Claims:** We will submit your claims and assist you in any way we reasonably can to help. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their requests. Please, be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company, we are not party to that contract.

**4. Credit and collection:** If your account is more than 90 days past due, you will receive a letter stating that you have a very short time to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. If the balance remains unpaid, you will be referred to a collection agency. It is the option of the physician to then consider discharge of the patient from the practice. If this occurs, you will receive notice by regular and certified mail stating that you have 30 days to find alternative care. During that 30 day period, we will continue to provide care on an emergency basis only.

***Please, see following page for acknowledgement signature.***



**Attachment 4: Financial Agreement Form Signature page**

I have read and understood the financial policy and agree to abide by its guidelines.

Print Patient/Member Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Person Signing (if other than the patient/member):

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_