AMD Primary Care
1202 Kingsley Ave.

Patient Financial Agreement

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

Please note "AMD Primary care" is a dba of Adesso Professional Services, LLC

PATIENT INFORMATION

Date: _____

Patient's Name: _____ Birth Date: _____

Address: _____

Social Security Number: _____ Cell Phone: _____Email: _____

* If email and cell phone number are provided, you are consenting for us to use them to contact you if needed

FANANCIAL RESPONSIBILITY

Registration: All patients must complete our patient information form, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.

Insurance: I understand that I am directly and primarily responsible for payment of all charges incurred for the services rendered by AMD Primary Care. AMD Primary Care utilizes FAIR Health's (www.fairhealthconsumer.org) to estimate your service cost. I understand that do to the individual needs of each patient this is only an estimate and in the event my care exceeds the estimated amount, I will be financially responsible for the full balance. I further understand that full payment of services is not contingent on any insurance, settlement or judgment payment. AMD Primary Care may file a claim for payment with my insurance company as a courtesy to me. If the insurance company fails to pay AMD Primary Care in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to AMD Primary Care.

Insurance waiver: We accept many insurance plans. If your insurance is not a plan we participate in, I understand I can be seen as a "private pay" client, and prompt payment in full is expected for services rendered. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage.

Assignment of benefits (including Medicare benefits): I hereby assign all payments and/or insurance benefits including Medicare benefits for medical services rendered to me or my dependents directly to AMD Primary Care. I hereby authorize AMD Primary Care to release medical information necessary to obtain payment. Additionally, I assign the right to take all necessary action to pursue full payment of rendered services. Including but not limited to, perusing all administrative appeals, all causes of action (litigation, suit). I assign to the right to pursue all causes of action for payment and other ERISA claims. AMD Primary Care reserves the right to bill patients for any amount not covered by your insurance.

Patient payment: All copayments and deductibles are to be paid at the time of service. This arrangement is part of your contract with your insurance company. Any account balance over 90 days will be subject to review for collection action.

Credit and collection: If your account is more than 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 has remained unpaid for more than 180days, it will be sent to a collection agency and if a reasonable solution hasn't been reached, we will discharge the patient from our practice. You will at that time be notified by regular and certified mail that you will have 30 days to find alternative medical care. During that 30-day period our physician/s will be able to treat you only on an emergency basis

Forms: There is a $20 fee for completing FMLA, sick leave, AFLAC, and disability insurance forms. This fee must be paid before the forms are completed. There is also a $5 fee for any forms that need to be faxed or mailed directly from this office.

Phone management fee: There will be a $29 charge for managing and treating a minor acute illness (e.g., cold, flu, or sinus congestion) over the phone. The phone management fee will be billed to you if your insurance does not cover the cost of this service.

Missed appointments: Our policy is to charge $50 for missed appointments not canceled within a reasonable amount of time (72hrs). These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

By signing this agreement, I acknowledged I have carefully read, understand and agree to the terms and conditions contained in this financial agreement.

Patient Signature: _____ Date: _____

Legal Representative Signature: _____ Date: _____

Name and relationship to patient: _____