Golden Isles Partners In Health, LLC

118 Northpark
Brunswick, GA 31520-2111
Office: 912-268-4994

Patient Name:_____ Golden Isles Partners In Health,

LLC Financial Agreement

PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have had the opportunity to review a copy of Golden Isles Partners In Health, LLC **Privacy Notice**. I understand that I am responsible to read this Notice and notify Golden Isles Partners In Heath, LLC, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand the notice included electronic access to my medication history. Golden Isles Partner In Health, LLC has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.pihgoldenisles.com.

Patient Signature: _____ **Date of Birth:**_____

Parent, Guardian or Legal Representative Signature:_____

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 Golden Isles Partners In Health, LLC. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services. Golden Isles Partners In Health, LLC will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment or procedure this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment.

Golden Isles Partners In Health, LLC may file a claim for payment with my insurance company as required by contractual agreement. If the insurance company fails to pay Golden Isles Partners In Health, LLC in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Golden Isles Partners In Health, LLC**.** 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.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is **my responsibility** to provide Golden Isles Partners In Health, LLC with a copy of my **current insurance** card. If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. **I will notify Golden Isles Partners In Health, LLC immediately upon any change in my insurance**.

INSURANCE WAIVER, NON-COVERED SERVICES WAIVER and OUTSIDE LAB SERVICES

I understand that if I do not have a copy of a current insurance card and I still wish to be seen. I can be seen as a "Private Pay" patient. You agree that neither Golden Isles Partners In Health, LLC nor you will file a claim for the visit. I will be required to pay the total cost of the visit in advance. In addition, there may be a service I desire, suggested or provided that is not covered under my insurance plan ("Non-Covered Services"); I understand I must pay for "Non-Covered" services. If feasible, a waiver will be completed for each "Private Pay" visit or "Non- Covered Service." I understand services sent to an outside lab are billed to my insurance or me by the lab and I will receive a separate invoice from the lab.

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ANNUAL EXAMS (Including Medicare Annual Visits)

Annual "wellness" exams are preventive visits and are not paid for by all insurance carriers. Medicare only pays for a portion of this exam (Pap, Pelvic and Breast Exam) once every two (2) years. I understand I am responsible for payment, if the exam or portion of the exam is not covered by my insurance.

Annual exams do not typically include problems I may be having – as problem visits may require longer time. If I am experiencing problems, the office may be required to reschedule another visit to address these concerns.

CONSENT TO TREAT

I hereby consent and authorize 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.

ADDITIONAL INFORMATION

Golden Isles Partners In Health, LLC accepts payments in: Cash, Debit and Credit Cards. Interest fees on all accounts over 30 Days will have a 25% interest rate charged to the account.

I may also be charged if I do not cancel my scheduled appointment within 24 hours of appointment, a fee of 75.00 will be charged to the credit card on file, for not paying my co-pay and/or co-insurance or patient responsibility including deductible at the time of service, for telephone management services, for educational materials, for payment agreements which extend beyond 12 months, and for other administrative expenses not covered by my insurance plan. Any declined credit card for missed appointment fees will be charged a fee of $50.00 "so please make sure you keep your credit card on file current. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to Golden Isles Partners In Health, LLC.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to **Golden Isles Partners In Health, LLC**. I hereby authorize **Golden Isles Partners In Health, LLC** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

SIGNATURE

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

Patient's Printed name _____ **Patient's Date of Birth:** _____

Patient's Signature: _____ **Date signed:** _____

Parent, Guardian or Legal Representative Signature: _____

Employee's signature who reviewed intake of form: