Patient Financial Agreement

Thank you for choosing us as your Primary Care Physician. We are committed to being a partner in providing conscientious medical care for you. Payment of the bill is considered an important part of that partnership. Thank you for reading our financial agreement. Please let us know if you have questions or concerns.

The following is a statement of our Financial Policy, which we require you to read and sign.

It is your responsibility:

• To understand your benefits plan.

• To know if a referral is required.

• The know if pre-authorization is required prior to a procedure.

• To know what services are covered.

Full payment for self-pay patients, co-payments and deductibles are due at the time of service. You may also be asked to pay your coinsurance at the time of service.

We accept cash, checks, Visa/MasterCard/Discover/AMEX. Any other arrangements must be made in advance with our Billing Office.

Your insurance policy is a contract between you and your insurance company. Payment of your bill is ultimately your responsibility. PrimeNet Medical Group Inc. is contracted with and bills most insurance carriers.

1. I have read and agree to this financial agreement.
2. I authorize and consent to the release of medical information necessary to bill and process insurances claims.
3. I authorize payment of medical benefits directly to the physician.
4. If we cannot successfully collect an outstanding balance and payment arrangements are not established within 30 days of statement, the cost of collection, including reasonable attorney fees shall be included as part of the obligation dues.

___________________________________	____________________________	____/____/______
Patient Name	**Signature**	**Date**