WOMEN'S CARE FLORIDA D/B/A NORTH FLORIDA OB-GYN ("PRACTICE") FINANCIAL AGREEMENT

Patient Name: _____

PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have had the opportunity to review a copy of **Women's Care Florida HIPAA Notice of Privacy Notice** dated **December 1, 2018** ("Notice"). I understand that I am responsible to read this Notice and notify Women's Care Florida d/b/a North Florida Ob-Gyn (the "Practice"), in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. The Practice 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 our website at www.nfobgyn.com. The Practice will provide me with a copy of the most recent Notice upon request.

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 the Practice. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services. For surgery and pregnancy, the Practice 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, procedure or pregnancy, 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. Any patient credits will be applied to my other outstanding patient balances prior to any refund issued. I further understand that such payment is not contingent on any insurance, settlement or judgment payment.

The Practice may authorize its management services company – Physician Business Services, LLC – to file a claim for payment and accept assignment with my insurance company as required by contractual agreement. If the insurance company fails to pay in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed. Should the account be referred to a collection agency or attorney for collection, the undersigned agrees to pay the collection agency's fee (based on a percentage of your account balance, the current percentage is 33%) and 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 the Practice with a copy of my **current insurance** card and, if required by my insurance, **to obtain a referral** from my Primary Care Physician. The Practice is not obligated to see patients without a valid referral. 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 the Practice immediately upon any change to 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/or valid referral, the Practice is not obligated to see me. But if I still wish to be seen, I can be seen as a "Private Pay"/"Self-Pay" patient. I agree that neither the Practice nor I, 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 that 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 laboratory are billed to my insurance or to me by the lab and I will receive a separate invoice from the laboratory.

ANNUAL EXAMS (Including Medicare Annual Visits)

Annual "well-women" 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 that 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 which 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

Payment may be made to Women's Care Florida, LLC (the "Practice") in the form of: Cash, Check, Debit and Credit Cards. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to me by the Practice. Patient credits are applied to other outstanding patient balances prior to any refunds that may be issued, including balances owed to other offices (units) of the Practice.

I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged if I do not cancel my scheduled appointment, 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.

ASSIGNMENT OF BENEFITS

For the services rendered by the Practice, I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits either to myself or to the party who accepts assignment (the "Practice"). I agree to hold the Practice, its subsidiaries and affiliates, their shareholders, officers, directors, employees and agents, harmless from any and all costs, liability and damages of and nature whatsoever, including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent.

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 Date of Birth:** _____

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

Parent, Guardian or Legal Representative Signature: _____

Employee's signature who reviewed intake of form: _____