Primary Care South, Inc.

Patient Name:

Date of Birth:

Billing Policy

For services provided by Primary Care South - Walton, and providers, I hereby agree to pay all charges, deductibles, co-payments, and/or coinsurance amounts determined not paid or allowable by health insurance payers. I understand that certain routine procedures and services may be ordered by my provider and may not be covered by my insurance. I understand and agree to pay these non covered charges for services that my provider deems necessary performed at Primary Care South - Walton.

ASSIGNMENT OF BENEFITS:

I hereby assign and authorize payment directly to Primary Care South - Walton any medical and surgical benefits otherwise payable to me. Should any insurance payment be received that is less than the physician's usual charge for the services provided, I will be responsible for the difference. I understand if my insurance provider denies payment for any service for any reason I will be responsible for those charges.

I also agree to pay all costs of collection including, but not limited to collection fees, reasonable attorney's fees, and waiver all claims of exemption under the law of the state of Florida. Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications. Forms must be signed and dated by the patient or responsible party.

AUTHORIZATION FOR RELEASE OF INFORMATION:

I hereby authorize Primary Care South - Walton to release any information acquired in my examination, treatment, and diagnosis to my insurance carriers and other physicians. If I am covered by insurance I agree to show my cards and supply any forms necessary to Primary Care South - Walton at each visit. I am also responsible for letting Primary Care South -

Walton know in writing of any changes in my demographic or insurance information. This release allows disclosure about the treatment, diagnostic testing, or other medical information including psychiatric, alcohol, drug abuse, HIV, cancer registry treatment, and follow-up and/or other confidential information. The recipients are prohibited from any re-disclosure of this information. The undersigned has the right to subsequently revoke this release. The revocation shall not pertain to information previously released. Information requested in good faith by any health care facility or physician for facilitating continuing care and treatment is authorized.

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PAYMENT OPTIONS:

Before receiving treatment at our office, all patients will be required to pay their copay.

For balances greater than $5.00, patients will receive two written statements at the provided mailing address.

Any balance unpaid 30 days after your insurance processes or 120 days from the date of service , whichever occurs first, may be sent to a collections agency at any time.

All “Self-Pay” or “Fee for Service” patient balances are due at the time of service.

Any overpayment will be held as a credit on the account unless a refund is requested in writing by the patient.

All returned checks or charges disputed with merchant services will result in a fee of $30 to the guarantor.

By providing my signature below, I acknowledge that I have read and accept Primary Care South - Walton’s Notice of Privacy Practices and Billing Policy. I authorize them to process my payment as indicated above.

Signature _____

Signature Date _____