

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.

1. Medical practice name: "Holcombe Emergency Medicine, P.A."

The physician is: Kevin W Holcombe M.D.

2. Patient payment: All copayments and deductibles are to be paid at the time of service.

3. Forms: There is a \$15 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 instead of mailed.

4. Registration:

All patients (or their caregiver/parent/guardian) must complete our New Patient Registration Form, which will be entered into our computer system to maintain accurate information. If/when this information changes over time, please update us.

5. Drivers License:

As part of patient registration, we will need a copy of your drivers license. If a minor, or under the guardianship of another, we will need that responsible person's drivers license.

6. Uninsured patients: We offer a 30-percent discount to our patients who do not have insurance. Please be advised that the discount is only good when the charges are paid at the time of service. If the charges are not paid at the time of service, the discount will be removed and payment of the full charge will be expected before the next visit. If a balance remains, you will receive a monthly statement that is due upon receipt. Any account balance over 90 days will be subject to review for collection action.

7. 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, it may be sent to a collection agency. If an account is sent to collection, it is the policy of this office to discharge the patient and possibly immediate family members from the 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 physicians will be able to treat you only on an emergency basis.

8. Phone management fee: There will be a \$40 charge for managing and treating a minor acute illness (e.g., cold, flu, or sinus congestion) over the phone. The phone management fee will not be billed to your insurance and is your full responsibility.

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

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines.

X _____ Date _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

