FAIRHOPE FAMILY MEDICINE, LLC
21875 Hwy 181
Fairhope, AL 36532
251-928-1442

Financial Responsibility Agreement

The physicians at Fairhope Family Medicine, LLC are committed to providing you with quality healthcare delivered in a timely and compassionate manner. In order for Fairhope Family Medicine, LLC to continue with our commitments to patients, quality and service please take a few moments to review the Financial Responsibility Agreement.

1. I understand and agree that I am responsible for the payment of my and/or my dependent's bill for medical services. **I agree to pay all charges at the time of service. As a courtesy, Fairhope Family Medicine, LLC will file a claim with my insurance company according to item 2 below.**

2. I understand it is my responsibility to provide Fairhope Family Medicine, LLC with my most current and accurate insurance card and information.

3. I understand that my insurance policy is a contract between my insurance company and myself. In order to process my claim, I hereby authorize Fairhope Family Medicine, LLC to furnish information concerning my illness or injury to insurance carriers, Medicare, the Workers' Compensation Bureau, or my employer as appropriate.

4. I understand that by signing below, I authorize my insurance company to make payment to Fairhope Family Medicine, LLC. I agree to pay all co-payments and deductibles at the time of service. **I agree to pay Fairhope Family Medicine, LLC within 14 days from the date of billing for any amounts not paid by my insurance company.**

5. I understand that Fairhope Family Medicine, LLC currently files with most major insurance plans. However Fairhope Family Medicine, LLC cannot guarantee that the insurance plan accepts them as a participating provider. And therefore may not pay all or any part of my bill. It is my responsibility to verify participating providers with my insurance company.

6. I understand that charges for care I receive will depend upon my illness or injury and treatment necessary to provide appropriate, quality care. If I receive a charge estimate over the phone, this is for informational purposes only; such estimates are not a guarantee of price. In addition, all bills are subject to review by qualified billing and medical coding professionals, who may determine that additional charges or a refund may be due; thus initial charges may not reflect my final bill.

7. I understand that Fairhope Family Medicine policy requests that invoices be paid within **14 days of the date of billing** and that my balance will be considered

delinquent if it is 45 days past due. I understand that my balance will include amounts due for medical services rendered to myself and for my immediate family members, including my spouse, children or any other person for whom I am financially responsible. I understand that a $5.00 fee will be charged for each statement mailed after the initial statement.

I agree that if my balance becomes delinquent, defined as 45 days past due, and is referred to a collection agency or attorney, **I shall be responsible for collection fees equal to 33 1/3% of the balance due in addition to the balance**. I further understand and agree that if legal action is taken to collect the balance, **I shall also be responsible for all court costs and all reasonable attorney fees**. I herby waive my rights under the laws and constitution of Alabama or any other state, to exempt our real or personal property from execution. I hereby authorize any collection agency or attorney to whom my account has been referred **to access and obtain a copy of my credit report** to be used for purposes of collecting any debt or judgment rendered against me.

8. FOR MEDICARE & MEDICARE REPLACEMENT/ADVANTAGE PLAN PATIENTS: As a Medicare participant, I further authorize Fairhope Family Medicine, LLC to release medical information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers as needed, for this or any other Medicare claim. I permit a copy of this authorization to be used in place of the original, and for payment of medical insurance benefits either to myself or to the party who accepts assignment. Furthermore, I understand that a part or all of my services I receive at Fairhope Family Medicine, LLC may be non-covered by Medicare. I acknowledge responsibility for payment of any non-covered charges.

9. In regard to treatment of minors, a divorced parent or legal guardian who accompanies a minor and gives permission for treatment is responsible for payment of the bill. This applies even if another parent or legal guardian has been determined by a court settlement or judgment to be financially responsible. Both parents/all legal guardians are jointly and severally responsible for payment of a minor's medical charges.

10. I understand that if my check is returned due to Non-Sufficient Funds (NSF), my account will be assessed a $35.00 NSF fee.

I HAVE READ AND UNDERSTAND THE ENTIRE AGREEMENT

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Signature of Responsible Party **Date**

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Printed Name **Date**