Patient Financial Agreement

Dear Patient,

This letter sets forth our office financial payment policy.

I understand that as a recipient of medical care I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement. Full payment is due at the time of delivery of service. I understand that a fee is charged for all visits, examinations, or medical reports. I agree that the determination of the professional services to be rendered by my doctor and the fees to compensate him for these services are matters which concern my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party payer (for example, insurance company, employer, etc.).

The undersigned hereby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims to obtain benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as if the undersigned had personally signed the particular claim.

I hereby authorize my insurance company to pay and hereby assign directly to Richard M. Vazquez, MD, SC all benefits. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my responsibility. Full payment is due at the time of service except if otherwise arranged or mandated by law.

Patient balances are due immediately and are not contingent upon receiving a statement. Insurance companies provide an explanation of benefits outlining payments and patient balances.

Should I fail to pay unpaid charges for more than 30 days, I authorize unpaid charges to be charged to the credit card provided below. Unpaid charges over 60 days will incur a monthly service fee of $25. Accounts with no activity for 60 days may be forwarded for further collection action. If I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency and attorney fees. Any and all advance collection fees incurred by the practice will be included in my final bill. I understand and agree that some additional charges may come through from my treatments that are not included in the initial estimated bill. I understand and agree that any such additional charges (or any applicable refund) will be processed to this credit card.

If a credit card is not presented to the practice, a deposit of $_______, to be applied to any and all unpaid patient balances will be provided. Should my insurance cover all services, the money will be refunded upon final insurance payment. There is a $25.00 service charge for a returned check.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND IN COMPLIANCE WITH THOSE TERMS, AGREE TO THE FOLLOWING:

1. Providing Richard M. Vazquez, MD, SC with complete and accurate billing information, including, but not limited to, a current insurance card, authorization numbers, and/or referral forms for each visit and/or procedure. I am responsible for all visits and procedures not properly authorized.

2. I will pay all applicable co-pays and outstanding patient balances as they become due. All co-pays and patient balances are due at each visit.

I give my consent to ____to provide medical care and treatment to the below named patient deemed necessary and proper in diagnosing or treating his/her/my physical condition.

I HAVE READ AND AGREE TO THE TERMS OUTLINED ABOVE

SIGNED (patient or guarantor) ____ Date: ________________

FOR (print patient name) ____