Palmetto Medical Group

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Patient Financial Responsibility Statement

Thank you for choosing Palmetto Medical Group, PLLC, as your primary care provider. The medical services you seek may require a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. By signing below and/or by receiving medical services from Palmetto Medical Group you understand and agree to

- You are responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier, which are not otherwise covered by supplemental insurance at the time of service.
- If you have a co-insurance plan, we ask for $50 at time of service and will bill you for the remainder.
- If you are self-pay you are responsible to pay the self-pay rate at the time of service and any additional services rendered during your visit.
- You are responsible for knowing your insurance policy such as your co-payment, deductible, co-insurance, etc.
- If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit same to Palmetto Medical Group until your patient account is paid in full. If you make a payment that results in a credit on your account, you authorize Palmetto Medical Group to apply the overpayment to any other account for which you are financially responsible, including your account, dependent's account, or on any account for which you are a Financial Responsibility Party, and any remaining balance will be returned to you.
- You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). You may generally expect this billing statement within thirty (30) days after your insurance company has responded to a submitted claim. You must notify the office manager of any errors or objections to the billing statement within thirty (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If there is a problem with your account, it is your responsibility to contact the office manager to address the problem or to discuss a payment plan.

- Whether you have insurance or are self-pay, payment is due within thirty (30) days of receipt of your billing statement. If any balance on your account is over ninety (90) days past due, your account will be in default and auto referred to a collection agency. You understand that Palmetto Medical Group has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. If you need to set up a payment plan, please reach out to our office manager.
- If payment is made by check and it is returned or declined for any reason, your account will be charged a return check fee of $30. Palmetto Medical Group will send you a notice stating your check was returned, then you will have 10 days from the date the notice was mailed to take care of the charges.
- Verified work related injury will be treated as workers' compensation, and we will bill the workers' compensation insurance as a courtesy. You must provide the workers compensation insurance along with the policy number. You are responsible for the completion of information with the employer and approval of the workers' compensation claim. In case your workers' compensation claim is denied, you will also provide us with your medical insurance information. If your claim is denied, we will bill your regular medical insurance. When the claim is no longer pending and any portion of your claim is ultimately resolved against you by workers' compensation and your medical insurance, you will be required to pay all amounts due within thirty (30) days if you have a balance.
- If you receive treatment as a result of a third-party liability injury (for example: motor vehicle collision) $160 is due at the time of service. Palmetto Medical Group will not put a hold on charges incurred relating to or arising out of third-party liability, we will not accept a delay in payment due to settlement disputes and/or litigation. We will not accept a letter of protection from an attorney as a guarantee of payment or assignment of third-party insurance payments.
- You will be charged a $25 fee for a missed appointment without 24 hours advance notice.
- The parent/guardian of a minor is responsible for payment of the minor's account balance.
- You authorize Palmetto Medical Group personnel to communicate by mail, answering machine messages, and/or e-mail according to the information provided in your patient intake forms. Palmetto Medical Group may use any information you have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers, to contact you for purposes related to your account, including debt collection.

Acknowledgement

By signing below, I acknowledges that: I have read, understand, and agree to Palmetto Medical Group provisions and agree to the specified terms; I agree to pay all charges due (or that become due) to Palmetto Medical Group for the patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; benefits, if any, paid by a third-party will be credited on the patient account; regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including collection agency fees; and failure to pay when due may subject me to late payment charges and can adversely affect my credit report.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

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Patient's Name

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(Print) Patient's/Guardian/Responsible party name

_____

Date

_____

Signature) Patient's/Guardian/Responsible party

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Relationship to patient