

**Financial Agreement**

MR# \_\_\_\_\_

Patient Name: \_\_\_\_\_

- 1) The Patient (or responsible party) agree that, in consideration of the services to be rendered to the above named patient, he/she will pay for all applicable office services at the time of the initial appointment. It is understood that the patient (or responsible party) is financially responsible to Cary Healthcare Associates, P.A. for charges. For your convenience, our office accepts cash, MasterCard, Visa, debit cards, and personal checks. A fee of \$25.00 will be charged for all checks returned from the bank unpaid.
- 2) Cary Healthcare Associates, P.A. requires a 24-hour advance notice for appointment cancellations. After the first failure to keep an appointment, the patient is subject to a charge (as specified in the cancellation policy attached) for any visits missed without proper notification.
- 3) Cary Healthcare Associates, P.A. will file directly with your insurance company if it is a carrier that we participate with. Individual insurance companies determine allowable amounts based on their specific plans. Payment for services are based on the allowable amount determined by your insurance company and will vary depending upon your policy. Your policy may ask you, the subscriber, to pay a deductible, co-insurance, or co-pay amount, and may have certain non-covered services. Services not covered or authorized by your insurance will be the patient's responsibility and will be directly billed to you.
- 4) Cary Healthcare Associates, P.A. will make reasonable attempts to collect approved benefits from your carrier for a period of 60 days. However, please remember that the patient (or responsible party) is ultimately responsible for the medical bill. You will receive a monthly statement showing the amount that is the patient's responsibility. Cary Healthcare Associates, P.A. reserves the right to turn any and all accounts that are not paid in full within 90 days to a collection agency. There will be a \$20.00 fee assessed to the patient's account in collections.
- 5) Cary Healthcare Associates, P.A. no longer files Worker's Compensation or Motor Vehicle Accident claims. Cary Healthcare Associates, P.A. will be willing to see patients who will file these types of claims, provided that the office services are paid *in full prior* to their appointment.
- 6) The patient (or responsible party) agree to authorize payment directly to Cary Healthcare Associates, P.A. of all insurance benefits payable with the understanding that Cary Healthcare Associates, P.A. will refund any overpayment to the person responsible for the account. The patient (or responsible party) further agree that any overpayment on this account resulting from collections from insurance companies not having coordination of benefits clauses or other parties may be applied to any delinquent or outstanding account balances owed by the patient (or responsible party) to Cary Healthcare Associates, P.A.
- 7) The patient (or responsible party) agrees to authorize Cary Healthcare Associates, P.A. to release medical information if requested by your insurance company to process payment for services rendered.
- 8) Medicare Beneficiaries Only) I hereby certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I hereby authorize any holder of medical or other information about me (or the above-named patient) to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made to Cary Healthcare Associates, P.A.
- 9) The patient (or responsible party) certifies that the information given is correct to the best of his/her knowledge.
- 10) I understand that I may revoke this consent at any time except to the extent that action based on this consent has already been taken. Consent for release of confidential information will expire automatically after one year from the date signed, except for the processing or financial claims.

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I have read and understand the cancellation policy stated above and agree to accept responsibility as described.

\_\_\_\_\_  
Patient Name or Responsible Party (Please Print)

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date