



FINANCIAL RESPONSIBILITY AGREEMENT

This Financial Responsibility Agreement (Agreement) is a legally binding contract between you and Anchor Medical Group (AMG). This Agreement supersedes any and all prior agreements between AMG and you concerning payment of our charges, and applies to all future charges you may incur. Please read this document carefully and ask a member of our staff to answer any questions which you may have before you sign this document.

CHARGES DUE AT THE TIME OF SERVICE: All Charges for our services are due at the time of the service except as provided in this Agreement.

INSURANCE BILLING: If you are insured by a company for which AMG is a Preferred Provider, we will bill your insurance company in accordance with our agreement with your insurance company. Otherwise, we will bill your insurance as a courtesy only, and we reserve the right to stop doing so at any time. Regardless of if we bill your insurance company, you are ultimately responsible for payment of all charges.

DEDUCTIBLE: If you know that you have not yet met your full insurance deductible at the time of service, you must pay the unmet portion of your deductible at that time, and we will bill your insurance company for the rest of your charges. If we bill your insurance company and any portion of our charges are not paid by your insurance company due to an unmet deductible, we will bill you for, and you must pay, such unpaid charges.

COPAYMENTS, COINSURANCE, AND LIMITS ON COVERAGE: Even after you have met your full deductible, your insurance may not cover 100% of our charges. If you know, or if we believe, that you have a copayment obligation, or there are applicable limits on your insurance coverage, you must pay all copayment amounts and any other amounts not covered by your insurance at the time of service, and we will bill your insurance company for the rest of our charges. If we bill your insurance company and any portion of the charges are not paid by your insurance company due to a copayment amount or limit on the coverage, we will bill you for, and you must pay, such unpaid charges.

USUAL AND CUSTOMARY CHARGES: AMG sets its fees independent of any health insurance company or other organization. If you are insured by a company for which AMG is a Preferred Provider, we have agreed to accept what your insurance company considers usual and customary charges in payment for our services. If AMG is not a Preferred Provider for your insurance company, and if we bill your insurance company and any portion of our charges is not paid by your insurance company because our charges exceed what your insurance company determines to be usual and customary, we will bill you for, and you must pay, such unpaid charges.

DUAL COVERAGE: If you have medical insurance from more than one source, AMG will, as a courtesy, bill your primary and secondary insurance, but we reserve the right to stop doing so at any time. We will not bill a third insurance under any circumstance. If we bill your secondary insurance, the above provisions concerning payment of deductibles, copayments, and other amounts will still apply. Regardless of whether we bill your secondary insurance, you will remain ultimately responsible for payment of all our charges.

MOTOR VEHICLE INSURANCE: AMG will not, in any case, bill a motor vehicle insurance company. All charges for any care which you receive related to a motor vehicle accident must be paid at the time of service. AMG will provide you with the necessary documentation so that you may be reimbursed by your motor vehicle insurance.

WORKER'S COMPENSATION: AMG will not, in any case, bill for Worker's Compensation.

AUTHORIZATIONS & PROCEDURES: The decision to perform any medical testing or surgical procedure is entirely between you and your Physician. However, in each case your insurance company will decide whether the service is covered by your policy. In the case where your insurance company does not cover a service, we will bill you for, and you must pay, all the charges for that service. AMG does not seek preauthorization from insurance companies before

providing services. Therefore, it is your responsibility to seek prior authorization from your insurance company should you need or wish to do so. Please be warned that prior authorization is not a guaranty that your insurer will pay for a specific service. You remain responsible for payment of all our charges in any event.

SERVICE CHARGES: The below listed service charges will not be billed to any medical insurance company and must always be paid by you directly. If your insurance covers this, you may request that it be billed. Ultimately you are financially responsible for these services. Interest charges, up to the amount allowed by law, may be added to the amount you owe if your account is overdue.

1. A "No Show" Fee will be waived for the first missed appointment. This includes being late for your appointment or failing to cancel or reschedule an appointment with less than 24 hours notice. You will be charged a \$50.00 No Show Fee after a second missed appointment. This is due in full prior to making another appointment. You will be dismissed from the practice if a third appointment is missed.
2. A charge of \$25.00 or more may be charged for phone calls with your Physician unless it is billed to your insurance.
3. A charge of \$25.00 or more may be charged anytime you request a Physician to complete paperwork.
4. A charge of \$30.00 will be applied to checks returned to us due to non-sufficient funds in your bank account.

TELEMEDICINE: AMG may use Telemedicine (Live two-way audio and video, telephone, text, email, portal) for clinical evaluations. Expected benefits include improved access to care by enabling you to be seen from home or another location. Risks include but are not limited to; a physician determining that the telemedicine encounter is not yielding enough information to make an appropriate clinical decision, which may require additional in-person visits; technology problems may delay medical evaluation and treatment. You have the right to withdraw consent to the use of telemedicine at any time. If the physician believes you would be better served by a traditional face-to-face encounter, the physician may stop the telehealth visit and schedule a face-to-face visit. The laws that protect privacy and confidentiality of medical information also apply to telemedicine. AMG does not seek preauthorization from insurance companies before providing telemedicine services. Therefore, it is your responsibility to seek prior authorization from your insurance company should you need or wish to do so. Please be warned that prior authorization is not a guarantee that your insurer will pay for a specific service. You remain responsible for payment of all our charges in any event.

CREDIT CARD ON FILE: AMG is committed to making our billing process as simple and easy as possible. We require that all patients provide a credit card on file with our office. We store your card number in a secure, compliant system. If you do not have insurance, or have one that we do not bill, we will immediately charge the amount due at the time of service unless you provide alternate payment. If you have insurance that we bill, we will mail your statement after your insurance processes your claim. We will run the credit card on file for the full balance on your account 14 days after our statement is generated and mailed. If you would like to pay for your balance in a different manner, you must contact us to do so. If your payment is declined and you do not contact us with an alternate method of payment within 30 days, a \$30 fee will be applied. If the full balance is not paid within the next 30 days, the unpaid balance will be subject to an additional finance fee of \$30. Further delinquency will be subject to additional finance fees (\$30 every 30 days). You will not be seen for an appointment if a balance over 30 days is unpaid. By signing this agreement, you agree to the above, and give AMG permission to charge your credit card for the balance due on your account.

If you do not pay your balance within 90 days your account will be sent to collections through **Cornerstone Credit Services, LLC.**

Patient Name (Print)

Patient's Date of Birth

Patient Signature

Date

Person Responsible for Payment (if not patient)

Relationship to Patient

Signature of Person Responsible for Payment (if not patient)

Date