Agreement to Pay

The patient/responsible party agree(s) to pay in full all charges submitted by Dr. Linda C. Clemons, Florence Family Practice ("F.F.P") during patient treatment unless F.F.P is legally obligated to accept payment for those charges solely from a third party. The patient/responsible party agree(s) to be fully financially responsible to F.F.P even though there may be insurance or other third party coverage, or even though the charges may exceed the amount reimbursed by insurance. In the case of HMOs or other third parties requiring specific referral authorization prior to making payment, patient acknowledges and agrees that any service rendered without the parties supplying the referral authorization will be considered a self-referral, for which the patient/responsible party will be solely responsible for payment. Patient/responsible party acknowledges that payment is due at the date of service. Patient/responible party agree(s) that failure to make payment when due is the basis for legal action, and agree(s) to pay any and all costs of collection, including responsible attorneys, and agree(s) that their obligations are joined and severable, permitting F.F.P to pursue either or both for payment.

Authorizations

The patient/responsible party understand(s) that the following authorizations are to be used by F.F.P to effect the collection of benefits in patient's behalf. These authorizations become effective on the date the first service is rendered, and remain in effect until specifically revoked in writing by patient/responsible party. Copies of this agreement will be as valid as the original.

The patient/responsible party authorize(s) the release and disclosure of any and all medical information related to patient's treatment and care to any entity, which is, or may be liable, for physician charges, or to any professional review organization associated therewith. The patient/responsible party authorize(s) the release and disclosure of all or any part of patient's medical records to any healthcare provider who may be of assistance, in opinion of F.F.P, in providing medical care and treatment for the patient, and/or for assistant in any reimbursement of benefits to which patient may be entitled.

The patient/responsible party authorize(s) and requests that payment of any authorized insurance benefits be made either to patient, or on patient's behalf to F.F.P, for the services furnished the patient by F.F.P. This authorization allows the office to file "assigned" claims only for the purpose of having benefits paid to F.F.P, and does not imply that F.F.P accepts insurance as payment in full, unless F.F.P has a contractual agreement with patient's carrier. The signatures below are deemed sufficient for all insurance forms on a continuing basis.

The signature below serves as authorization for services rendered by Florence Family Practice for the above named patient, and serves as authorization for the release of information necessary to file insurance claims and assign benefits otherwise payable to the policyholder to the physician or group indicated on the claim or request for payment. **I understand that I am financially responsible for all balances not covered by my insurance carrier and that a copy of my signature is as valid is the original.**

Date_____

Signature_____