PHA ADULT MEDICINE
DELIVERING THE CARE YOU NEED
Text PHA to 55469

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FORM 2 : PAYMENT POLICY AGREEMENT

"I" collectively refers to the patient, his/her guardian and/or his/her surrogate decision maker.

Assignment to Pay Insurance Benefits

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare or its representative, private insurance, Medicaid and any other health plans or third-party payers to PHA-Adult Medicine (PHA). This assignment is for services rendered to me by PHA and its providers. This assignment will remain in effect until revoked by me in writing. A photocopy or electronic version of this assignment is considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment. PHA reserves the right to refuse said assignments.

My Responsibility to Pay Balance Due

I agree that if I am a cash paying patient, I am expected to pay full payment at time of service. If I have insurance, I agree to pay applicable co-pay at the time of service. If my deductible has not been met, PHA will collect a portion of the office visit and submit claim to my insurance. Even though insurance will be filed, I agree to pay all charges not covered by my insurance and which are determined to be my responsibility. I agree that PHA will supply a statement of balance owed and I will pay within 30 days of date of such statement. If I am more than 30 days past due, I will be considered delinquent. If I have financial difficulty paying my bill, I will inform PHA this and take advantage of payment plans or other agreement made to bring my account current. I also understand that while PHA values its commitment to serve me, it reserves the right to terminate the patient-physician relationship for delinquent account status not made current or for clear refusal to make payments. If termination is necessary, a 30-day notice will be given to find another primary care physician. During this time, PHA will provide care for medical emergencies only. PHA reserves the right to refer my account to a collection agency and I am responsible for collection fees.

In addition to the value of the check, there will be a $25 charge for bounced checks.

In addition, there are charges for completing forms to be used outside of the medical record: Examples: Utility forms, Employment Forms, School Forms, Disability Forms, Driver's Permit, Home & Community Based Services Waiver Forms, Handicap Permit Forms, Nursing Home Placement Forms.

Attestation

I acknowledge that I understand the above. I understand that a photocopy or electronically stored copy of this signed document is as valid as the original.

_____ Signature _____ Date

_____
Patient/Guardian/Surrogate Decision Maker