PATIENT FINANCIAL AGREEMENT

Thank you for choosing Suburban Primary Care as your Primary Care Provider. We are committed to being a partner in providing conscientious medical care for you. Payment of the bill is considered an important part of that partnership. Thank you for reading our Financial Agreement. Please let us know if you have any questions or concerns.

The following is a statement of our Financial Policy, which we require you to read and sign. It is your responsibility:

1. **To understand your benefit plan.**
2. **To know if your provider is in your network.**
3. **To know if a referral is required.**
4. **To know if prior authorization is required.**
5. **To know what services are covered.**

Payment At Time Of Service: Full payment for self-pay patients, co-payments, coinsurance and deductibles are due at the time of service. You may also be offered payment plan options to avoid any lapse in payments due and be asked to provide a credit card on file. Credit Card payments are processed the 10th of every month. ***Federal and State law does not allow routine write-offs of co-payments, coinsurances and deductibles as it violates the payor and physicians' legal binding contracts***.

We accept Cash, Checks, Visa/MasterCard/Discover/AMEX.

Assignment of benefits: I hereby request that payment of authorized insurance carriers and all other insurance benefits be made on my behalf to MPS KOHLI, MD, SC dba Suburban Primary Care for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services. Your insurance policy is a contract between you and your insurance company. Payment of your bill is ultimately your responsibility. Our clinic contracts with and bills most insurance carriers.

Authorization to release information: I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to MPS KOHLI, MD, SC dba Suburban Primary Care any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

Additional Charges: The clinic will charge $50.00 for "NO SHOW, SAME DAY CANCELLATION or RESCHEDULED" appointments.

Completion of ANY forms will be subject to $25 charge.

Failure To Keep Appointments: If patients miss (3) consecutive appointments, they will no longer receive further care and may be fired from the practice. Patients will receive, in writing, a termination letter requesting to find a new PCP after (30) days from receipt of the letter.

1. I have read and agree to this Financial Agreement.

2. I authorize and consent to the release of medical information necessary to bill and process insurance claims.

3. I authorize payment of medical benefits directly to the physician.

4. Account balances 90 days past the due date without payment arrangements will be turned over to the collection agency automatically.