Notice of Privacy Practices Acknowledgement

I acknowledge that Jennie Stuart Medical Group has provided or offered me a copy of its Notice of Privacy Practices, which I have the right to decline. The Notice of Privacy Practices provides a description of how the practice may use and disclose my protected health information, as well as other rights I have regarding my health information.

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Responsible Party Signature Date

Assignment of Benefits

All professional services rendered are charged to the patient and due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health / medical plans, to issue payment check(s) directly to Jennie Stuart Medical Group for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

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Responsible Party Signature Date

Financial Agreement

Thank you for choosing Jennie Stuart Medical Group as your healthcare provider. We are dedicated to providing you the most efficient, quality care and service possible. Your understanding of our financial policy is an essential element to your care. If you have any questions regarding any aspect of our policy, please feel free to present your question to our billing department.

Full payment is due at the time of service. If you have insurance and have signed the Assignment of Benefits statement, we will bill your insurance carrier for you if we are a provider on your plan. An insurance policy is a contract between the patient and the insurance company. We cannot guarantee payment of your claims. Reduction or denial of insurance claims does not relieve your financial obligation. You are responsible for know what services are covered under your plan and which costs you are required to pay.

I understand that I am financially responsible for all charges whether they are covered by insurance. Balances are due within thirty (30) days of the billing statement date and eligible for collections after 90 days. All uninsured patient must pay the balance in full prior to service, unless prior arrangements have been make with our business office.

I agree that if this account is not paid when due, and JSMG should retain an attorney or collection agency for collection, I agree to pay all the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 30% of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on your account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing.

I understand that I will be financially responsible for any return check fees in addition to the amount of the check.

I understand that JSMG requires a charge for medical forms and / or copies of medical records that I request to be completed and I am responsible for payment.

I agree to pay all co-payments and deductibles at the time service is rendered.

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Responsible Party Signature Date