PATIENT FINANCIAL & PAYMENT POLICY

THIS NOTICE DESCRIBES YOUR FINANCIAL RESPONSIBILITIES AND OBLIGATIONS
PLEASE REVIEW IT CAREFULLY

This is an agreement between Bay Point Healthcare, LLC, a Florida Corporation, as a creditor, and the Patient/Debtor named on this form.

In this agreement the words “I”, “you,” “your,” and “yours” mean the Patient/Debtor. The word “account” means any account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Bay Point Healthcare, LLC (BPHC) and/or its affiliated entities.

Insurance

Insurance is a contract between you and your insurance company. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Please understand that insurance reimbursement can be delayed for multiple reasons. In fact, insurers will routinely stall, deny, and reduce payment. Insurers routinely process claims resulting in additional invoicing at no fault of BPHC. We will NOT under any circumstance falsify or change a diagnosis or symptom in order to convince an insurer to ‘pay’ for care that is not covered, nor do we delete or change the content in the record that may prevent, or cause, it to be considered covered.

_____ Initials	HMO Plans: Any co-payments required by an insurance company must be paid at the time of service.
_____ Initials	PPO Plans: BPHC has agreed to accept the discounted rate from your plan, and we will **estimate** balances to the best of ability. However, since these are **estimates** only, I understand that any remaining balances due to deductibles, co-insurance, and non-covered claims are my responsibility to pay BPHC. Your appointment may be rescheduled if your estimated amount due is not paid at check in.
_____ Initials	Missed Appointment Fee: I understand that *Appointment Reminders are a courtesy.* Failure to show up for, or cancelation of an appointment with less than 24-hour notice, may result in a no-show fee assessed to my account. The no-show fee is subject to change. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be discharged from the BPHC practice location.
_____ Initials	After Hours Services: Please be advised additional fees may be subject for services rendered after hours, which includes evenings (after 5pm), weekends, and holidays.
_____ Initials	Administrative Charges: I understand that additional administrative charges may apply for items such as the completion of medical forms, telephone consultations, and physician letters. (This is not an exhaustive list)

Guarantee of Payment

For value received, including but not limited to the services rendered, I agree to guarantee and promise to pay BPHC all charges and expenses incurred in my treatment, including those expenses not covered by any insurance policy presently in force, including any co-payment and/or deductible. Unless specifically agreed in writing, all charges shall be paid at discharge or upon presentation of the first bill by BPHC. Unpaid accounts shall bear interest at the maximum rate provided by Florida law. I understand and agree that if BPHC is required to bring a claim or file an action to enforce this agreement, BPHC shall be entitled to recover from me its reasonable attorney's fees, expert fees, court costs, and any other costs of collection, in addition to the amount owed BPHC for its services. Based on permissible purpose under the Fair Credit Reporting Act, BPHC reserves the right to run a credit report for the sole purpose of determining my ability to meet incurred expenses directly related to my treatment.
***** Payments received will be posted to the oldest outstanding balance on your account.***

Returned Checks: A Returned check will result in a service fee based on the face value of the check and may require all future payments to be made by cash or credit card. A collection agency may be used in the recovery of debt attributed to returned checks, in addition to the payment of the check plus any court cost, reasonable attorney fees and any bank fees incurred by the payee in taking action as pursuant to *Florida Statute 68.065*.

Divorce, Dependent and Child Custody Cases: Regarding divorce, the presenting guardian accompanying the person (minor or disabled adult) who receives care at BPHC is responsible for payment of copays, co-insurance and/or deductibles at the time of service.

Assignment of Benefits

I hereby assign, grant and transfer to BPHC, now and in the future, all of my rights and interest in the following: (a) Any and all benefits now or in the future owed or receivable by me or on my behalf from any insurer, health maintenance organization, PPO, employer health benefit plan or other third-party payer for those costs I incur in receiving services from BPHC. The included insurance policies and insurer would include, but are not limited to, health, auto, UM and PIP; and (b) Any and all monies or other benefits paid or payable to me and/or my attorneys from any settlement, judgment or verdict which is obtained as a result of the injury or medical condition for which my debt to BPHC was or is to be incurred. I further authorize, request and direct any and all assigned insurers to pay directly to BPHC the amount due me in any potential or pending claim for medical benefits under the respective policies, expressly including all PIP policies. I agree that should the amount received by BPHC be insufficient to cover the entire expense of service, including the co-payment and the deductible, I will be personally responsible for payment of the difference. I also understand and agree that if the nature of the services rendered by BPHC are not covered by said insurance policy, I am responsible to BPHC for payment of the entire bill.

Name of Patient	**Name of Guardian/Personal Representative/Responsible Party**
Signature of Patient	**Signature of Guardian/Personal Representative/Responsible Party**
Date	**Date**