**SEKINE, RASNER & BROCK OF JACKSONVILLE, LLC**
**FINANCIAL AGREEMENT**

## PATIENT INFORMATION

**PATIENT'S NAME** _____
Last First M.I.

**ADDRESS** _____

**BIRTHDATE** _____/_____/_____ **DAYTIME TELEPHONE NUMBER** _____
Month Day Year

**SOCIAL SECURITY NO**. _____ **CELL PHONE*:**_____

**E-MAIL*:** _____

*If you provide your e-mail and/or cell phone to us, we may use such information to contact you by e-mail and/or text for appointment reminders, waiting lists, missed appointments and marketing of services provided by Sekine, Rasner & Brock of Jacksonville, LLC ("SRB").

## APPOINTMENT INFORMATION

In consideration of our patients, you might be asked to reschedule if you do not arrive on time for your appointment.

If you determine you need to cancel/reschedule your appointment, please contact our office a minimum of 24 hours in advance of your scheduled appointment time. Failure to comply with this policy will result in a $35 charge.

## FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at **SRB**. I am responsible for any applicable deductible or co-payments prior to the provision of services. **SRB** will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, or procedure this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. **SRB** may file a claim for payment with my insurance company as a courtesy to me. If the insurance company fails to pay S**RB** in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to **SRB**.

**SRB** is a wholly owned subsidiary of Florida Woman Care, LLC ("FWC") who may file a claim for payment and accept assignment with my insurance company as required by contractual agreement.

Payment may be made to FWC OR **SRB** in the form of: Cash, Check, Debit and Credit Cards. In the event that I receive a check directly from my insurance company payable to me for services rendered by **SRB**, I understand that this payment belongs to **SRB**. I agree to endorse the back of the check as shown below and promptly deliver the check to **SRB**.

Patient credits are applied to other outstanding patient balances prior to any refunds that may be issued, including balances owed to other wholly owned subsidiaries of FWC. I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged if I do not cancel my scheduled appointment, for not paying my co-pay and/or co-insurance or patient responsibility including deductible at the time of service, for telephone management services, for educational materials, for payment agreements which extend beyond 12 months, and for other administrative expenses not covered by my insurance plan.

## COLLECTION AGENCY AND DISCHARGE FROM SRB

Should my account be referred to a collection agency or attorney for collection, I shall pay all costs of collection, including a reasonable attorney's fee. Balances not paid in full or payment arrangements scheduled within 60 days of the initial statement are considered delinquent and the **SRB** Billing Office will charge a collections fee of $25.00 and place the account in inactive status. Patients who do not pay their outstanding bills within 90 days of the initial statement will be discharged from the **SRB** practice.

## RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is my responsibility to provide **SRB** with a copy of my current insurance card and to obtain a referral from my Primary Care Physician (if required by my insurance). **SRB** is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay patient and be financially responsible for the total amount of the services provided. I will notify **SRB** immediately upon any change in my insurance.

## INSURANCE WAIVER, NON-COVERED SERVICES WAIVER AND OUTSIDE LAB SERVICES

I understand that if I do not have a copy of a current insurance card and/or valid referral, **SRB** is not obligated to see me. But if I still wish to be seen, I can be seen as a "Private Pay" patient. I agree that neither **SRB**, nor I, will file a claim for the visit. I will be required to pay the total cost of the visit in advance. In addition, there may be a service I desire, suggested or provided that is not covered under my insurance plan "Non-Covered Services"; I understand I must pay for Non-Covered Services. If feasible, a waiver will be completed for each Private Pay visit or Non-Covered Service. I understand services sent to an outside lab are billed to my insurance or me by the outside lab and I will receive a separate invoice from the outside lab.

## CONSENT TO TREAT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. **SRB** and other FWC subsidiaries may share one electronic medical record ("EMR"). To facilitate the provision of my medical care, I consent for **SRB** to access my medical records maintained by any other FWC subsidiary.

## ANNUAL EXAMS

Annual "well-woman" exams are preventative visits and may not be paid for by all insurance carriers. I understand that I am responsible for payment, if the exam or portion of the exam is not covered by my insurance.

Annual exams do not include problems I may be having. If I am experiencing problems, the issue will be addressed by the provider and the service will be billed to my insurance company. I understand that I may be billed for a co-pay deductible or coinsurance as shown on the explanation of benefits received from my insurance company.

## COMPLETION OF FORMS

There will be a $30 charge for the completion of forms, i.e., insurance disability, FMLA paperwork, etc.

## ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to **SRB**. I hereby authorize **SRB** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan. In the event I receive payment directly from my insurance company for services rendered by **SRB**, I agree to promptly endorse any check received to **SRB**.

**ASSIGNMENT OF MEDICARE BENEFITS**

I hereby authorize and assign all payments of authorized Medicare benefits for medical services and/or surgical procedures rendered to patient, directly to **SRB**. I hereby authorize **SRB** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by Medicare for which I have signed an ABN.

**SIGNATURE**

**BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.**

**Date:** _____

**Patient Signature:** _____

**Parent, Guardian or Legal Representative Signature:**_____

**Witness Signature:**_____