PIEDMONT MEDICAL
ASSOCIATES

Patient Financial Agreement and Financial Responsibilities

Piedmont Medical Associates is dedicated to providing our patients with information regarding their healthcare coverage and financial responsibilities. In consideration of services provided by Piedmont Medical Associates (PMA), Patient or undersigned patient representative agrees to the following:

1. **Emergency Medical Services**
   Patient understands his/her right to receive an appropriate medical screening exam performed by a doctor or other qualified medical professional to determine whether Patient is suffering from an emergency medical condition, and if such a condition exists, stabilizing treatment within the capabilities of PMA staff and facilities, even if Patient cannot pay for such services, or does not have health insurance benefits.
2. **Patient Responsibility for Payment of Medical Services**
   In return for **Medical Treatment/Services** rendered to Patient, Patient understands and unconditionally agrees to the following:
   - Patient agrees to pay all co-payments, deductibles, or co-insurances.
   - Patient agrees that he/she will be charged PMA standard fees/rates for services not covered by Payor or deemed self-pay.
   - Patient agrees to pay for any services determined not to be covered by Patient health benefit plan or insurance company.
   - Patient is aware that he/she is not relieved of liability by any extension of time granted for the payment of these charges, not by the acceptances by PMA of a patient note or any third person.
   - If PMA requires legal assistance to collect an account, Patient agrees to pay the cost incurred.
   - PMA may use data from third parties such as credit reporting agencies to verify demographic data or evaluate financial options and by this authorization expressly permit sources and employers to provide PMA with information requested.
3. **Assignment of Insurance of Health Plan Benefits**
   Patient acknowledges the assignment and authorization for direct payment to PMA for all insurance and health plan benefits and settlements whether hospital, medical, or liability insurance including but not limited to, the proceeds of any settlement or judgement of any third party claim as payment for any and all services performed at a PMA facility. Patient agrees that the insurance company's or health plan's payment to PMA pursuant to this authorization shall discharge the insurance company's or health plan's obligations to the extent of such payment.
4. **Filing of Third Party Claims**
   Patient acknowledges that upon verification of healthcare coverage, PMA will submit a claim for payment of insurance benefits and accept payments from third party payors to be credited to Patient's account as they are received. Patient agrees that the filing of insurance claims is performed as a courtesy service and in no way relieves Patient of the obligations to pay in full. Additionally, Patient acknowledges the following:
   - Patient is responsible to follow up with insurance carrier or employer within 30 days to ensure Patient's charges are fully paid.
   - Patient understands that he/she is financially responsible for charges not paid according to this agreement. If a credit balance exists on his/her account, Patient assigns credit to be applied to any unpaid accounts for which Patient or the insured or guarantor is also responsible. Any money remaining after Patient's account is paid in full will be refunded to Patient.
   - Patient also understands that different Payors have different requirements for payment including, but not limited to, pre-certifications and authorization or that the services be medically necessary. Patient understands that it is his/her obligation to know his/her Payor's requirements and ensure that they have been fulfilled, including having a valid authorization for service in place prior to Medical Treatment/Service. Failure to have a valid authorization will lead to Patient and/or Guarantor being responsible for payment of the full charges.
   - Insurance companies will often deny claims when the insurance is not presented at the time of service. Many insurance companies have requirements for authorization prior to or within twenty-four hours of service. If you present insurance information after the actual date of service or treatment, we will file a claim with your insurance company on your behalf. Although, you will be held responsible for visit charges if the insurance denies the claim as untimely because of late presentation of coverage or for lack of timely authorization due to late presentation of health benefits coverage.
5. **Authorization To Release Information**
   PMA is authorized to release information contained in the patient record. The information authorized to be released shall include, but is not limited to, infectious or contagious disease information, including HIV or AIDS-related evaluations, diagnosis or treatment; information about drug or alcohol abuse or treatment of same and/or psychiatric or psychological information. Patient waives any privilege pertaining to such confidential information. PMA, its agents, and employees are hereby released from any and all liabilities, responsibilities, damages, claims and expenses arising from the release of information as authorized above. Reasons for releasing a patient's record include, but are not limited to, insurance company(s), their agents or other third party payor and/or government or social service agencies which may or will pay for any part of the medical expenses incurred or authorized by representatives of PMA, as mandated by law, or to alternate care providers, including community agencies and services, as ordered by Patient's physician or as requires by Patient or Patient's family for post hospital care. **PATIENT ACKNOWLEDGES AND AGREES THAT PATIENT'S RECORDS WILL BE AVAILABLE TO ALL PMA AFFILIATED ENTITIES AND PROVIDERS, AND TO NON-PMA AFFILIATED REFERRING PROVIDERS IN COMPLIANCE WITH THE PROVISIONS OF MEANINGFUL USE.** Patient also agrees for PMA to service accounts or to collect liabilities owed, to receive contact by telephone at any telephone number associated with their record, including wireless telephone numbers, which could result in charges to Patient. PMA or its agents may also contact Patient by sending text messages or use of an email address that Patient provides. PMA may contact Patient thru use of voice messages or MyChart messaging.

6. **Debit/Credit Card Payment Authorization Form:** we are dedicated to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. To best accomplish this task in a cost-effective manner for all our patients, we will scan your credit card of choice at check-in, scan your picture identification card, scan your current insurance card and we ask that you adhere to PMA's financial authorization policy by agreeing to the below:
   - I am ultimately responsible for payment of all charges for services I receive from PMA to include medical services deemed covered and non-covered by insurance. As a courtesy, PMA will submit claims for reimbursement with my insurance company.
   - Immediate payment may be expected at the time of service. This may include a co-pay and additional payment if PMA determines that the cost of your visit will not be reimbursed by your insurance provider. This often happens if your deductible is not yet satisfied or met or verification of current coverage is not available at the time of service.
   - PMA may deny service or charge a service fee if I am unable to pay agreed co-pay at the time of service.
   - It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
   - I agree to allow PMA and/or its designated payment agent to scan my debit/credit card information, insurance card, and picture ID.
   - I understand that my signature and payment information will be maintained thru an file encryption. The applicable payment card or bank account number will be truncated and "tokenized" by the payment agent to fully maintain security of payment information.
   - If justified, PMA may offer the option of paying share of costs via an automated payment plan. I understand that I may incur interest expense beyond my balance in exchange for this convenience. Interest does not apply if full balance is paid by due date.
   - I authorize PMA and/or its designated payment agent to apply charges to my payment card and/or bank account for all amounts owed to PMA for medical visits, or other medical services, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after applying all insurance reimbursements received), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by PMA for "no show" of a scheduled appointment or provide timely notice of appointment cancellation.
   - In the case of my balance due that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly eStatement for any outstanding balance. I am responsible for paying this balance by its due date to avoid paying possible interest.
   - I will be provided with a courtesy eStatement (electronic patient account statement) after insurance reimbursements have been applied to my account and after payment processing of authorized balance due that is deemed patient responsibility. Transaction credit / debit card confirmation receipts will be maintained in my patient file or may be emailed to me at my email on file.
   - I authorize PMA and/or its designated provider to send eStatement and invoices to my email address noted on my account. I understand that it is my responsibility to maintain a current email on file, eStatement in lieu of a mailed paper statement.
   - This authorization will remain in effect until I (Patient) provide written notice of cancellation to PMA. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify PMA in writing of any changes to my personal information.

7. **Validity of Form:** Patient acknowledges that a copy or an electronic version of this document may be used in place of and is as valid as the original. **Patient confirms that he/she has read and understood and accepted the terms of this document and he/she is the patient, the patient's legal representative or is authorized by Patient as Patient's general agent to execute the above and fully accept its terms.**

Patient / Patient Representative **Signature**	Patient Name (**PRINT**)	Date	Time

Relationship to Patient	Reason Patient is unable to sign

Piedmont Medical Associate Representative **Signature**	Piedmont Medical Associate Representative Name (**PRINT**)	Date	Time