INFINITY PRIMARY CARE

NAME: _____ DOB: _____

PATIENT FINANCIAL RESPONSIBILITY FOR NUTRITIONAL COUNSELING

Thank you for choosing Infinity Primary Care, PLLC as your health care provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Patient Financial Responsibility Policy, which we require you to read and sign prior to enrolling in the program. Please let us know if you have any questions or concerns.

For your convenience we accept cash, check, Visa, MasterCard, American Express and Discover.

I understand I am financially responsible for treatment provided to me or my legal dependent by Infinity Primary Care PLLC.

I understand my insurance policy is a contract solely between me and my insurance company.

I understand that we will submit the physician office visit claim to your insurance plan.

I authorize my insurance plan to make payments for covered services directly to my physician.

I understand that I am responsible to pay at the time of service **for copays**, deductibles, non-covered services or services provided by a physician or other provider. I understand a $10.00 fee will be added if I do not pay my copay at the time of services.

If my physician does not participate with my insurance company, or if my insurance company has not paid the claim within 45 days, I understand the balance becomes my responsibility and I must pursue reimbursement directly from my insurance company. If there is a balance on my account, a statement of my charges and payment will be sent to my mailing address.

I authorize Infinity Primary Care, PLLC to communicate with my health insurance company, in accordance with their Privacy Policy, regarding my policy coverage. I further authorize Infinity Primary Care, PLLC to release information required by my insurance company to make payment for services rendered.

I understand a payment plan may be set up if I have financial difficulties. Charges over 90 days past due without a payment plan, may be sent to a collection agency and may result in being discharged from the practice.

I understand there is a $10.00 late fee for amounts over 60 days. I understand there is a $30.00 fee for returned personal checks.

I understand that the cost of the Medical Nutritional Counseling initial visit is $140. Follow up visits are $70. We will submit these charges to your insurance provider. The patient will be responsible for any copays your insurance company requires for these visits.

I have read the Patient Financial Policy and understand my responsibilities.

_____ _____

Signature of Patient or Legal Guardian/Guarantor Date

_____ _____

Printed Name of Patient Date of Birth

_____ _____

Witness Date