EAGLE PHYSICIANS

Acct #:_____

Patient Name:_____ DOB:_____ Todays' Date:_____

PATIENT PAYMENT POLICY

Eagle Physicians and Associates, P.A. appreciates the confidence you have placed in our physicians, extenders and staff. It is our mission to help you Stay Healthy. To keep you informed and aware, the following patient payment policy applies to all Eagle patients.

Eagle is contracted with most major insurance companies. You are encouraged to visit our website at www.eaglemds.com and click on Insurance and Payment Policies for a complete list of contracted plans. You may also call us at 336-274-9134 for information. Eagle will gladly file all claims to our contracted insurance companies and will apply all contracted adjustments to your balance. In return, we require that you honor the contractual obligations set for you by your insurance company. Please make sure you know the deductible, coinsurance and copay amounts your plan requires you to pay. We are obligated by our contracts to collect these amounts from you. If you are unable to honor your contractual financial obligation at the time of your service, you may be asked to reschedule your appointment. If there is an additional balance due after your insurance company has processed the claim, payment in full is due upon your receipt of an Eagle billing statement. For large balances that cannot be paid in full, you are required to contact Eagle Business Services at 336-274-9134 to set up a payment plan.

Effective 5/1/2019, Eagle will no longer file insurance claims with non-contracted insurance plans. As our patient, it is your responsibility to verify, prior to receiving medical services from Eagle, whether or not we are contracted with your insurance plan. If we are not contracted with your plan, you will be offered a prompt pay adjustment of 30% at the time of your visit. Upon payment, we will provide you with a receipt and a summary of your services which will include all information necessary for you to file to your insurance company for reimbursement. Any payment issues with a non-contracted insurance plan are the responsibility of the patient.

Payment is expected at the time of service for patients with no insurance, patients with non-contracted insurance plans, and patients who have insurance with a contracted plan but have not met their deductible. Eagle accepts payments via cash, check, MasterCard, Visa, American Express, Discover Card and CareCredit. Payment collected at the time of service is an estimate based on the information available at the time of service. New uninsured patients or patients who have insurance but have not met their deductible will be required to pay $100 prior to any service being rendered. Any additional estimated balance due will be collected at check out. If charges are less than $100, the overpayment will be refunded. If there are additional charges posted after check out, payment in full is due upon the patient's receipt of an Eagle billing statement. You may be eligible for a prompt payment adjustment with payment in full on the date of service. This does not apply to any non-Eagle services such as outside labs or diagnostic imaging.

Collection Agencies. Patients who do not respond to Eagle's efforts to collect on an overdue balance may be turned over to an outside collection agency and they may be dismissed from all Eagle sites. If this becomes necessary, Eagle will attach a 15% service fee.

I have read this information and I understand the above patient payment policy

Patient Initials_____

AUTHORIZATION/RESPONSIBILITY ACKNOWLEDGEMENT

I acknowledge and understand that I am financially responsible for my medical care. I agree to pay for services as they are provided, unless covered by contract between the provider and my insurance plan. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement.

I authorize the release of my medical information necessary to process insurance claims. If assignment of benefits is accepted, I authorize payment to Eagle Physicians & Associates.

Patient Initials_____

PATIENT PRIVACY ACKNOWLEDGEMENT

I acknowledge that I have been offered Eagle Physicians & Associates Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

Patient Initials_____

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____