Infectious Diseases
EXPERT GROUP OF NW FLORIDA

FINANCIAL ARRANGEMENT

In connection with rendering health care services by Infectious Diseases Expert Group of NW Florida (IDEG), the patient and/or the responsible party for the patient is required to indicate which method of payment is applicable to the patient. The patient is also responsible for any deductible and/or out of pocket expense determined by the individual insurance plan. Method of payment accepted is cash, check, and money order, Visa, MasterCard, Discover and American Express. The fee for **returned checks is $25.00** and will be charged to your account. By signing below, you acknowledge that any agreement in regards to your insurance plan is an agreement between you, the policy holder and the carrier and that any claims filed by IDEG is only done as a courtesy to our patients.

INSURANCE PLAN: I have commercial insurance and have assigned benefits to authorize payment to IDEG in accordance with the assignment of Health Insurance Benefits I have executed on this date. Any payment made will be forwarded to IDEG. I will pay applicable charges not paid by the insurance as billed by IDEG.__________ (initials)

WORKERS COMPENSATION: A claim for Workers Compensation benefits has been filed by e employer and approved by his/her insurance carrier. In an event Workers Compensation denies my claim, I will assume financial responsibility for all medication, supplies, equipment and clinical services as rendered and invoiced by IDEG._________ (initials)

MEDICARE: I have Medicare coverage and have authorized payment to IDEG in accordance with the assignment of benefits that I have executed on this date. I also understand that Medicare **does not cover prescription drugs**, therefore, will not pay for outpatient IV antibiotics outside the physician's office or hospital. Per Medicare guidelines, if the service or supply is statutorily excluded, when filed to Medicare, it will result in an automatic denial, making it the patient responsibility. If there is a secondary insurance, IDEG will file that claim._________ (initials)

UNINSURED: I have no medical insurance and will pay IDEG 100% of my office visit charge at the time service is rendered. I will pay IDEG 25% of the estimated cost of therapy prior to the start of therapy. I will pay the remaining balance in 3 equal monthly installments. I am aware that the therapy could change, therefore changing the final balance amount by IDEG._________(initials)

In consideration of and to induce IDEG to retain myself as a private patient, I, the undersigned assumes full responsibility for and agrees to pay all costs and expenses of myself of every kind and description of services, facilities, mediation and any other items supplied and/or furnished to the patient. This is an original undertaking on the part of the undersigned, and obligations of the undersigned hereunder are the direct and primary obligations of the undersigned. No extensions, indulgences or forbearance's which may be granted to the patient and no delays or lack of diligence in enforcing any rights against the patient shall in any manner release the undersigned of affect the undersigned's liability hereunder. If the undersigned is more than one person, every obligation(s) hereunder shall be joint and several. The Obligations of the undersigned hereunder shall be cumulative with and in addition to all other remedies against patient. Dater Insurance Verified: ________ Insurance Calendar Year/Plan: _________ Past Deductible: ________ Met $_________Coverage once Met________% OOP $_________ Met $________ Lifetime Max $________ Physician Office Co-Pay $_________ Estimated Patient Responsibility $ _________ Balance Due $ _________________________

I WOULD / WOULD NOT like a copy of this form: (please circle and initial) ______________

____ ____/_____/________
Signature of Patient or Legal Guardian Date

____ ___________________ ___________________________
Patient Name (please print) Patient Date of Birth Patient Social Security Number

Heather H.______ ______/______/_________
Witness Date