Southern Crescent Family Practice, LLC
455 Forest Parkway
Forest Park, GA 30297
678-705-0100 (P)
678-235-1800 (F)

Patient Financial Agreement and Responsibilities

Southern Crescent Family Practice is committed to providing patients with information regarding their coverage and financial responsibilities. In consideration of services provided by Southern Crescent Family Practice (SCFP), the Patient or undersigned representative acting on behalf of the Patient agrees to the following:

1. Emergency and Labor 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 the SCFP staff and facility. Patient understands that emergency services that are beyond SCFP ability to treat in an ambulatory-physician/office based setting, if Patient does not have medical insurance or Patient is not entitled to Medicare or Medicaid.

2. Non-Medicare Patient Responsibility for Payment

In return for **Medical Treatment/Services** rendered to the Patient; Patient understands and unconditionally agrees to the following:

- Patient agrees to pay all co-payments, deductibles or co-insurances prior to or at the time of service/visit.
- Patient understands and agrees that he/she will be charged SCFP standard charge master rates for all services not covered by a Payor, in which case if in- network will be the Payors in-network allowable charges, for out-of network Payors SCFP charges based on the Payors usual and customary or reasonable fees.
- Patient specifically agrees to pay for any services, which are determined not to be covered by any 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 acceptance of SCFP, a promissory note of the patient or any third party person, or debit/credit card automatic withdrawal system.
- If SCFP requires legal assistance to collect an account, Patient agrees to pay the cost incurred for such collections.
- SCFP may use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options and by this authorization expressly permit sources and employers to provide SCFP with all information requested.

3. Assignment of Insurance or Health Plan Benefits

Patient acknowledges the assignment and authorization for direct payment to SCFP for all insurance and health plan benefits and settlements whether commercial medical or medicare insurance including but not limited to, the proceeds of any settlement or judgment of any third party claim as payment for any and all services performed at SCFP. Patient agrees that the insurance company's or health plan's payment to SCFP 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 SCFP does not submit or accept payment of insurance benefits from third party payors ("Payors") to be credited to Patient's account. Patient agrees that the filing of insurance claims is performed as a service and in no way relieves Patient of the obligation to pay in full. Additionally the Patient acknowledges the following:

- Patient is responsible to follow up with any insurance company or employer within 30 days to see that Patient's bill is paid promptly.
- Patient understands that he/she is financially responsible for charges not paid according to this agreement. If Patient overpays the amount owed on his/her account, Patient assigns credit to be applied to any other existing unpaid accounts ("Other Accounts") for which the Patient or the insured or guarantor is also responsible. Any money remaining after the Patient's account and Other Accounts have been paid in full will be refunded to the patient or guarantor.
- Insurance companies will often deny claims when the insurance is not presented at the time of service. Please contact our Billing Department with your Insurance/Payor information by email at billing@scfp.llc. Otherwise your account may be considered self-pay/uninsured and you will be responsible for the total bill.

5. Assignment of Medicare Benefits

Patient certifies that the information given in applying for payment under Title XVIII of the Social Security Act is correct. Patient requests that the payment of authorized benefits be made on Patient's behalf to the provider of Medical Treatment/Services. Patient assigns the benefits payable for Medical Treatment/Services rendered by SCFP and all Healthcare Professionals rendering care and/or treatment to Patient and authorizes SCFP and Healthcare Professionals to submit claims to Medicare for payment. Patient authorizes any holder of medical or other information to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. Patient understands he/she is responsible for any deductibles, co-payments, co-insurances, and/or non-covered services as defined by Medicare to be paid in accordance with all terms and conditions specified herein.

6. Assignment of Medicaid Benefits

Patient certifies that the information given in applying for payment under Title XIX of the Social Security Act is correct. Patient authorizes any holder of medical or other information to release to the Social Security Administration or its intermediaries or carriers any and all information needed for this or related Medicaid secondary Payor claims. Patient requests payment of authorized benefits be made on Patient's behalf to the provider of Medical Treatment/Services. Patient assigns the benefits payable for Medical Treatment/Services rendered by DCFP and all Healthcare Professionals rendering care and/or treatment to Patient and authorizes SCFP and Healthcare Professionals to submit claims to Medicaid for payment.

7. Authorization to Release Information

SCFP is authorized to use and release information contained in the patient record as described in the SCFP Notice of Privacy Practices and as otherwise permitted or required by law. The information authorized to be used or released will 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 and hereby releases SCFP, its agents and employees from any and all liabilities, responsibilities, damages, claims and expenses arising from the use and release of information as authorized above. Permissible uses and disclosures include, but are not limited to, disclosures to insurance companies, their agents or other third party payors and/or government or social service agencies that may or will pay for any part of the medical/hospital expenses incurred or authorized by representatives of SCFP; alternate care providers, including community agencies and services, for post-hospital care, as ordered by Patient's physician or as requested by Patient or Patient's family or as otherwise permitted by law; or SCFP affiliates and contractors for SCFP operations purposes, such as quality improvement, compliance and risk assessment activities. **PATIENT ACKNOWLEDGES AND AGREES THAT PATIENT'S RECORDS WILL BE AVAILABLE TO ALL SCFP AFFILIATED ENTITIES AND PROVIDERS, AND TO NON-SCFP AFFILIATED REFERRING PROVIDERS IN COMPLIANCE WITH THE PROVISIONS OF MEANINGFUL USE**. By consenting to treatment and accepting financial responsibility for any such treatment, Patient also understands and acknowledges that (a) SCFP, from time-to-time, may call and/or text the cell number Patient has provided or email treatment-related information to Patient, such as appointment and exam confirmations and reminders, wellness checkups, hospital pre-registration instructions, pre-operative instructions, post-discharge follow-up, prescription notifications, Medicare-required surveys, and home healthcare instructions and (b) Patient's preferences to receive, change or stop these and other types of communications from Southern Crescent Family Practice may be done by logging into the Healow Patient Portal at any time.

8. Consent Timeframe and Applicability

The above agreements are applicable to all ambulatory, outpatient, or physician office-based services and are valid for a term of one (1) year from the date of signature below.

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. **The 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 duly authorized by the patient as the patient's general agent to execute the above and accept its terms.**

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

______________________	______________________
Relationship to Patient	Reason Patient is unable to sign

______________________	______________________	________	________
SCFP Healthcare Representative Signature	SCFP Healthcare Representative Name (**PRINT**)	Date	Time