FINANCIAL AGREEMENT

Dr. Rahman believe that part of good healthcare practice is to establish and communicate a financial policy for our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1.PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit.

2. INSURANCE: We are participating providers with several insurance plans. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. It is the patient's responsibility to confirm his or her benefits, covered services and to select a primary care provider who is in their insurance network.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office or Explanation of Benefits from your insurance company indicating a balance due.

3. AFTER HOURS CARE or care on days the clinic is closed including prescriptions refills or telephone assessment and treatments will be charged an urgent care or after hours fee of $30 or a holiday fee of $50.

4. LATE CHARGES of 12% annually will be applied to all patient balances 90 days from the initial statement date. Balances not paid within 90 days of statement may be sent to collections.

5. RETURNED CHECKS will incur a $40 service charge. You will be asked to bring cash, certified funds, or a money order to cover the amount of the check plus the $40 fee prior to receiving additional services from our office. Stop payments constitute a breach of payment and are subject to the $40 service fee and collections action.

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6. FORMS FEES: completing insurance forms, copying medical records, etc. requires office staff time and time away from patient care for our doctors. We require pre payment for completing forms, copying medical records, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication, varying from $10 to $30. Medication Prior Authorizations require a fee of $25 to be paid before initiating. Copying fees for Medical Records is $25 for the first twenty (20) pages and $0.25 per page in excess of twenty. The practice will have 15 business days in which to copy records before making them available for the patient to pick up, and these 15 days will commence after payment for copying has been received, and after the patient has signed the form authorizing records' release.

7. CANCELLATIONS OR MISSED APPOINTMENTS: If you miss your appointment and do not cancel at least 24 hours in advance, you will be charged a fee of $50 for a missed appointment or $75 for missed Physicals/Wellness Visits (new & established patients). If you miss or no show for your Naviwell appointment, you will be charged a $50 fee.

In the event a patient has incurred three (3) documented "no-shows" and/or "same-day cancellations," the patient may be subject to dismissal from the clinic. The patient's chart is reviewed and dismissals are determined by a physician only, no exceptions, in accordance with our clinic's guidelines.

I have read and understand the practice's financial policy and I agree to be bound by its terms.

I also understand and agree that such terms may be amended by the practice without notice.

Signature of Patient: _____

(or Guarantor, if applicable)

Printed Name of patient: _____

Date:_____