



NORTHVIEW
WELLNESS

Northview Wellness PC
3020 Holcomb Bridge Road
Norcross, GA 30071
P. 678-626-1868
F. 678-626-1898

Financial Responsibility Agreement

This Financial Responsibility Agreement (hereinafter referred to as the "Agreement") delineates the financial obligations and responsibilities of the undersigned patient (hereinafter referred to as the "Patient" or "Guarantor") for all services rendered by [Clinic Name] (hereinafter referred to as the "Clinic"). The Patient acknowledges and agrees to be financially responsible for all charges incurred, irrespective of insurance coverage, and to adhere to the terms set forth herein.

Insurance Information

The Clinic engages with a variety of insurance carriers. It is incumbent upon the Patient to understand the specifics of their insurance benefits and coverage.

In-Network Insurance

For Patients whose insurance plans are in-network with the Clinic, the following provisions apply:

- **Copayments:** The Patient agrees to remit any required copayments at the time services are rendered. Copayments are pre-determined amounts stipulated by the Patient's insurance policy.
- **Deductibles:** The Patient is responsible for satisfying any deductible requirements as dictated by their insurance plan. A deductible is the predetermined amount that the Patient must pay out-of-pocket before insurance coverage commences.
- **Coinsurance:** Post deductible satisfaction, the Patient will be liable for coinsurance. Coinsurance is a percentage of the cost of services that the Patient must pay, as specified by their insurance plan.
- **Verification of Benefits:** While the Clinic will make reasonable efforts to verify the Patient's insurance benefits and provide an estimate of financial responsibility, the Patient acknowledges that these are estimates and that ultimate financial responsibility lies with the Patient.

Out-of-Network Insurance

For Patients whose insurance plans are out-of-network, the following terms apply:

- **Out-of-Network Charges:** The Patient acknowledges that services rendered may be reimbursed at a lower rate or not at all by out-of-network insurance plans, resulting in potentially higher out-of-pocket expenses.
- **Balance Billing:** The Patient agrees to pay the difference between the Clinic's charges and the amount reimbursed by their out-of-network insurance plan, known as balance billing.
- **Prepayment Requirement:** The Clinic may require the Patient to prepay an estimated amount for services rendered under out-of-network plans. The Patient agrees to pay such amounts as determined by the Clinic.

Self-Pay

For Patients who do not have insurance coverage or choose to self-pay:

- **Self-Pay Rates:** The Clinic offers predetermined rates for self-pay services, which will be communicated to the Patient prior to service provision.
- **Payment at Time of Service:** The Patient agrees to pay for services in full at the time they are rendered, unless alternative arrangements are made with the Clinic's billing department.

Financial Obligations

The Patient understands and agrees to the following financial obligations:

- **Responsibility for Payment:** The Patient is ultimately responsible for the payment of all charges for services provided by the Clinic, including but not limited to, copayments, deductibles, coinsurance, and any charges for out-of-network services.
- **Billing and Payment Terms:** Statements for any balances due will be issued by the Clinic. Payment is due upon receipt of the statement, unless other arrangements have been pre-established. The Clinic reserves the right to impose interest on outstanding balances and to pursue collection actions, including legal proceedings, if payments are not made in a timely manner.
- **Returned Payments:** A fee may be assessed for any returned checks or denied electronic payments due to insufficient funds or other reasons.
- **Missed Appointments:** Fees may be charged for appointments missed or canceled without adequate notice, as per the Clinic's cancellation policy.
- **Payment Plan Options:** The Clinic may offer payment plans for patients experiencing financial difficulty. Such plans must be agreed upon in writing and will outline the terms and conditions for the repayment of outstanding balances.

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- Termination of Services for Nonpayment: The Clinic reserves the right to terminate services for nonpayment. Should the Patient fail to remit payment for services rendered, the Clinic may discontinue providing non-emergency services. The Patient will be given notice of such termination and an opportunity to settle their account before services are discontinued.
- Collections for Nonpayment: In the event of nonpayment, the Clinic may refer the Patient's account to a third-party collection agency or pursue legal action to recover owed amounts. The Patient agrees to be responsible for all costs associated with such collection efforts, including but not limited to, collection agency fees, court costs, and reasonable attorney's fees.

Authorization and Release of Information

- Insurance Claims: The Patient authorizes the Clinic to release any medical or other pertinent information necessary to process insurance claims. The Patient also authorizes the payment of medical benefits directly to the Clinic for services rendered.
- Changes in Insurance or Contact Information: The Patient agrees to promptly notify the Clinic of any changes in their insurance coverage or contact information.

Acknowledgment and Signature

By signing below, the Patient acknowledges that they have read and fully understand the terms of this Agreement. The Patient agrees to the financial responsibilities and obligations as outlined and consents to the terms specified herein.

Patient Name: _____

Patient Signature: _____

Date: _____