Frank Johnson Jr., M.D.
13400 N Meridian Street, Suite 600
Carmel, IN 46032

FINANCIAL AGREEMENT

Patient Name (please print):_____ Today's Date: _____

We would like to take this opportunity for you to review our financial agreement for services rendered. We are dedicated to providing the best possible care to you. We regard your complete understanding of the financial responsibilities as an essential element of your care and treatment.

SELF PAY PATIENTS:

You are considered a self-pay patient if you fall into one of the following categories:

*No insurance coverage
*Involved in a liability case (we do not file 3rd party insurance)
*Incomplete insurance coverage information (no card at time of appt.)

In these instances, you are responsible for payment of your bill **in full** at the time services are rendered.

RESPONSIBLE PARTY/GUARANTOR:

You are financially responsible for your medical services regardless of insurance coverage, any divorce decree, or court order. The party who seeks medical care and signs the financial agreement for a minor is considered "the guarantor" and is financially responsible for payment and copays at time of service.

CO-PAY AND DEDUCTIBLES:

Some insurance companies no longer cover office visit charges, have a co-pay requirement, or have deductibles to be met. **You will be required to pay the non-covered charges, co-pay, or outstanding deductible amount at each appointment.** Deductibles will be collected prior to surgery as indicated by your insurance company.

INSURANCE COVERAGE:

Your insurance company**, including workers' compensation,** is legally responsible to you. Our relationship is with you, our patient, not the insurance company. Consequently, all charges incurred are your responsibility. The obligation to assure payment in a timely manner lies with you regardless of what your insurance company chooses to do. Unfortunately, you cannot always depend on your insurance company to make timely payment on your behalf. Delays, misplaced (lost) claims or the need for additional information from the policyholder are not uncommon. If the insurance company has attempted to obtain additional information from you in order to process a claim and you fail to respond, the balance will become your responsibility.

NON-SUFFICIENT CHECKS/CLOSED ACCOUNTS:

Your account will be charged $25.00 for any returned check due to non-sufficient funds or closed account. If payment is not made, your account will be subject to our collection process where additional fees could be incurred. You are responsible for the amount of the check and any additional fees charged associated with bank fees.

I have read, understand, and agree to comply with this Financial Agreement. I authorize the office of Frank Johnson Jr., M.D. to release medical information required to obtain payment for services rendered to the patient. I understand if my account should become delinquent, I will be responsible for all expenses involved in collection efforts including collection agency fees, court costs, and any attorney fees that are incurred to obtain unpaid account balance.

_____ _____

Patient Signature or Responsible Party of a Minor Date

_____

Office Employee