

**Premier Medical Group, P.C.
Financial Responsibility Agreement**

- Payment is expected at the time of service. Payment may be made by cash, check, or major credit card. Third party payment or assignment is generally accepted for services. Any deductible, co-insurance or co-payment is payable at the time of service.
- **PAYMENT GUARANTEE:** The undersigned severally agree, whether signing as a patient or guarantor, to guarantee payment of the account in accordance with the standard rates and terms of Premier Medical Group, P.C. in Clarksville, Tennessee. I understand that my insurance, if any, is a contract between myself and the insurance company, except in certain cases where Premier has a specific contract with my PPO, HMO, or other third party payor. I further understand that any balance remaining after insurance approved or denies payment is my responsibility to pay, including any amount not paid by a secondary or supplemental insurance policy.
- If full payment is not received within 60 days of billing, Premier Medical Group reserves the right to charge interest of 1.5% per month (18 percent APR) or the highest rate allowed by law.
- In the event the charges incurred are not paid in full when due and collection activity is instituted, whether by a collection agency or an attorney (or both), I agree to be responsible for and pay, in addition to the charges incurred, all costs associated with such collection activity including, but not limited to, reasonable collection fees, attorney fees, court costs, and contingent fees to collection agencies of not less than thirty-five percent.
- Premier Medical Group reserves the right to transfer unpaid balances to outside entities for collection, such as banks or other financial institutions and who may report unpaid balances to credit bureaus.
- The provider of service has the right to terminate services based on noncompliance of this agreement.
- Have you applied for or do you currently have TennCare or Medicaid coverage? Yes No If YES, which one: TennCare Medicaid

Release of Information

- I hereby authorize Premier Medical Group, P.C. to release all medical information (including, but not limited to information relating to mental health evaluation and treatment, sickle cell anemia, alcohol and drug abuse diagnosis and treatment, HIV status, AIDS or AIDS related diagnoses, if any such information exists) to all my agents, or the Social Security Administration, as may be required or requested for the processing of claims for insurance, social security, disability, or Workers' Compensation or for other insurance purposes.

Authorization to Pay Insurance Benefits

- I hereby authorize the payment of any insurance or other medical benefits directly to Premier Medical Group, P.C.

Notice of Privacy Practices

- I have received a copy of Premier Medical Group's Notice of Privacy Practices.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, OR HAS BEEN READ, THE FOREGOING, THAT HE/SHE UNDERSTANDS THE FOREGOING, THAT HE/SHE HAS RECEIVED A COPY THEREOF, THAT HE/SHE HAS BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS THAT HE/SHE MAY HAVE CONCERNING THE FOREGOING, AND THAT HE/SHE IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT. THE UNDERSIGNED, HAVING READ AND UNDERSTOOD THE AGREEMENT, ACCEPTS THIS FINANCIAL RESPONSIBILITY AGREEMENT.

Patient's Name (Please Print) Date

Patient's Signature Date

Responsible Person (Guarantor) Date Relationship to Patient

Responsible Person (Guarantor) Date Relationship to Patient

I have reviewed the above information and conditions with the patient or his/her representative and he/she appears to fully understand these conditions.

Signature of Registering Personnel

Date