Goshen Medical Practice – Dicky Bhagat MD & Debby Gunden NP
2240 Karisa Drive, Suite 1 – Goshen, IN 46526 – Ph 574-534-6757 – Fax 574-547-0357

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name:_____ Date:_____

This is an agreement between Goshen Medical Practice, as creditors, and the individual responsible for payment (named above on this form) regarding payment for services provided to the above named patient by Dr. Dicky Bhagat, M.D and any other physicians or staff at Goshen Medical Practice.

In this agreement the words "you," "your," and "yours" mean the Individual Responsible for payment. The word "account" means the account that has been established in the patient's name to which charges are made and payments credited. The words "we," "us," and "our" refer to Goshen Medical Practice. By executing this agreement, you are agreeing to pay for all services that are provided to the above named patient.

Monthly Statement:
If there is a balance on the Patient account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge if any, and any payments or credits applied to the account during the month.

Payments:
Unless other arrangements are approved by us in writing, the balance on the statement is due and payable when the statement is issued, and is past due if not paid within 30 days of the statement date. Payments made by credit card /debit card will incur an additional convenience fee which is subject to change based on credit card company fee. Please take note that this fee may change occasionally based on the credit card rates.

Late Payment Fee:
GMP will charge $10.00 for every additional statement or reminder letter sent on unpaid balances after the non payment of a bill after 30 days of receiving the first statement. Payment is expected upon receiving the first statement.

Charges to Account:
We shall have the right to cancel your privileges to make charges against the account at any time. Future visits would then need to be paid at the time of service.

Required Payments:
Any co-payments required by an insurance company must be paid at the time of service.

Payment options if you have no insurance:
Full payment is expected at the time of service. You may choose to pay by cash, check, or credit card on the day that treatment is rendered.

Contracted Insurance:
If we are contracted with the Patient's insurance company and the patient has a co-payment, you must pay the co-payment at the time of service. It is the insurance company that makes the final determination of the Patient's eligibility for reimbursement for services. You are responsible for payment of all deductibles and any amounts not paid by the insurance company (which are applied to the account balance).
If the Patient's Insurance company requires a REFERRAL and/or PREAUTHORIZATION, you are responsible for obtaining it. Failure to obtain the referral and /or preauthorization may result in the Patient receiving a lower payment or no payment from the insurance company.

Non-contracted Insurance:
You are responsible for payment of all co-payments, deductibles and any amounts not paid by the Patient's insurance company. For those insurance companies where we do not have a contract , you are responsible for submitting claim forms to the Patient's insurance company, and full payment will be expected at the time of service . However, at your request , we may bill the Patient's primary insurance company as a courtesy.

Additional information required:
It is your responsibility to send in any additional information requested by the Patient's insurance company that is required for the processing of the insurance claim. If reimbursement to our office is delayed due to the need for additional information, you will be responsible to pay the entire amount billed to the patient, and seek reimbursement from the insurance company.

Credit History:
By signing this Agreement, you give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau and/or a collection agency.

Returned check fee:
There is a fee (currently $25) for any checks returned by the bank in addition to any bank charges for the same.

Missed Appointment Fee:
GMP will be charging a $40 fee for no shows and /or cancellations done less than 48 business hours and/or working hours prior. **Please read and intial here _____**

GMP will be charging a $75 fee for no shows and cancellations done less than 48 business hours and/or working hours prior for preventative (routine wellness visits). **Please read and intial here _____**

Divorce:
In case of divorce or separation, please provide us with updated account information regarding patient accounts for children. The party responsible for the account prior to the divorce or separation will continue to be responsible for payment on the account until a new party signs a Financial Responsibility Agreement. We will continue to send account statements to you until a new Financial Responsibility Agreement is signed. If the divorce decree requires someone other than yourself (e.g. the other parent) to pay all or part of the treatment costs for your child, it is your responsibility to collect from the other parent until the other parent signs a Financial Responsibility Agreement so that we may directly
bill the other parent.

Transferring of records:
The Patient (or authorized representative) must request in writing and pay a reasonable copying fee if for copies of his/her medical records sent to another doctor or organization. The amount of the fee is based on the number of pages we need to copy and follows the guidelines from Indiana Department of Insurance for Record Copying Fees. The Patient will be required to authorize us to include all the relevant information, including payment history on the account.
GMP will be sending the medical records requested on an encrypted CD.
This encrypted CD complies with HIPPA, SOX and DHS initiatives, and this secures your sensitive data using military grade FIPS 140-2 validated 256-bit AES encryption.

Workers Compensation:
We do not see workers compensation claims in the office unless referred specifically by another provider as a one time referral only.

Personal Injury:
If the Patient is being treated as part of a personal injury lawsuit or claim, we require verification from the Patient's attorney prior to the initial visit. Payment of the bill remains the responsibility of the Individual Responsible for the Payment. You are responsible for submitting Patient claims to the insurance company or other party. Payment is expected in full at the time of service.

Department of Transportation (DOT) physicals:
We provide DOT physicals at an approximate charge of $250.00 which includes completion of the required form. Payment for this is expected in full at time of service.

Disability physicals:
We do not provide physicals for "proof of disability" in the office and the Patient will be referred to another physician.

Physical /Annual well visit exams : _
This is a waiver signed by the patient to inform you that occasionally the insurance companies do not cover for a physical/annual exam along with an office visit on the same day. Please be advised that if that happens then you will be billed for the remainder balance due which the insurance did not cover. This can be avoided by keeping the office visit separate from the well exam. It is your responsibility to let GMP staff know when your last physical/annual well visit was to ensure it is only done after the 365 day period . We give vaccines per the CDC recommendations based on the age of the patient and coverage may vary depending upon your insurance. Please be aware and check with your insurance.

Lab Tests/ Blood Work:
You understand that it is your responsibility to let GMP staff know once you set up your lab/blood work appointment at any outside lab. This is to enable our staff to send in your lab orders. Failure to do so might result in inconveniencing you while having to wait at your lab appointment or even having to reschedule because of missing lab orders. You also understand that GMP will not be responsible for lab orders to be done for other physicians outside of GMP. It is also your responsibility to let GMP know before the blood work if you want any/all of the labs /blood work to be billed as screening labs. It will not be changed after the labs have already been billed to the insurance company. Please also make note that they might not be able to be billed as screening labs every time due to insurance regulations. **Please read and intial here** _

Waiver of confidentiality:
You understand and agree that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that the Patient received treatment at our office may become a matter of public record.

Collection Fees:
Patients with overdue accounts may be terminated from our practice and / or the account balances reported to a credit bureau or a collection agency. By signing this Agreement, you agree that if the account is turned over to a collection agency, you will be responsible not only for the account balance and any late fees, but will also be responsible for payment of any reasonable legal fees and costs associated with the collection of the account balance. If your account gets turned into precollections there will be an additional fee of $10.00 which will be added to your past due account balance over and above any statement fees/ late payment fees charged.

Change in demographics information:
It is your responsibility to alert us of any change in your demographic information including but not limited to address change, telephone number change, insurance change, employment changes etc.

Forms:
We may charge a $15.00 fee for completing any form not related to payment for services (including FMLA, camp health forms, etc.). The fee is to be paid at the time the Patient requests the form(s) to be completed. All forms require a minimum of 48 hours notice to complete. It may take longer depending upon the physicians schedule and complexity of the form.

Drug assistance forms:
We do not complete these forms in our office. You will be referred to an appropriate agency.

Mail Order Prescriptions:
We do not fax /mail any mail order prescriptions from our office- This would be the patient's responsibility to send these in with printed prescriptions from our office.

I have read and understand this Financial Responsibility Agreement and my obligations for payment of the Patient's account.

Individual Responsible for Payment (Please Print): _____

Signature:_____Date:_____
Relationship to Patient: _____