NORTH FLORIDA SURGEONS, P.A.
FINANCIAL AGREEMENT

PATIENT INFORMATION

DATE: _____

PATIENT'S NAME: _____
Last First M.I.

ADDRESS: _____

BIRTHDATE: ____/____/____ **DAYTIME TELEPHONE NUMBER:** _____
Month Day Year

SOCIAL SECURITY #: _____ **CELL PHONE*:** _____

E-MAIL*: _____

*If you provide your e-mail and/or cell phone to us, we may use such information to contact you by e-mail and/or text for marketing of services provided by North Florida.

PRIVACY NOTICE ACKNOWLEDGMENT

North Florida Surgeons, P.A. consists of wholly-owned subsidiaries where medical services are provided (collectively referred to herein as "**North Florida**"). I acknowledge that I have received and read a copy of **North Florida** Privacy Notice ("Notice") to review. **North Florida** has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location and on their website at www.nflsurgeons.com at all times. **North Florida** will provide me with a copy of its most recent Notice upon my request.

E-MAIL CONSENT

I acknowledge that I have received and read a copy of **North Florida** E-mail Consent. I understand that if I want to correspond with **North Florida** by e-mail that I must agree to the terms of the E-mail Consent, check the appropriate box and sign below.

☐ **I WANT** to correspond with **North Florida** by e-mail. I understand the risks associated with the communication of e-mail between **North Florida** and me. I consent to the conditions outlined in the E-mail Consent. Any questions I may have had were answered to my satisfaction.

Patient Signature: _____ **Date:** _____
Parent, Guardian or Legal Representative Signature: _____
Relationship to Patient: _____

☐ **I DO NOT** want to correspond with **North Florida** by e-mail.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is my responsibility to provide **North Florida** with a copy of my current insurance card and to obtain a referral from my Primary Care Physician (if required by my insurance). **North Florida** is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay patient and be financially responsible for the total amount of the services provided. I will notify **North Florida** immediately upon any change in my insurance.

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at **North Florida**. I am responsible for any applicable deductible or co-payments prior to the provision of services. **North Florida** will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, or procedure this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. **North Florida** may file a claim for payment with my insurance company as a courtesy to me. If the insurance company fails to pay **North Florida** in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to **North Florida**. Should the account be referred to a collection agency or attorney for collection, the undersigned agrees to pay the collection agency's fee (based on a percentage of your account balance, the current percentage is 33%) and all costs of collection, including a reasonable attorney's fee.

CREDIT CARD ON FILE

I provide a valid credit card (the credit card has not expired and has not reached its available credit limit) to be retained on file to pay any balance owed for my medical services. In the event that my credit card expires or has reached its limit, I am responsible to provide a new valid credit card. I further understand that the billing address for the credit card on file must match the address that appears on my monthly credit card bill or bank statement. I agree to pay such total amount charged in accordance with the agreement governing the use of such credit card. I hereby authorize **North Florida** to charge my credit card for payment of the medical services rendered. If I have entered into a payment plan, I authorize **North Florida** to charge my credit card to pay the payments owed under the payment plan.

Exact name as it appears on credit card: _____

Circle Card Type: __ VISA __ M/C __ AMEX __ DISCOVER

Card #: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Verification #: _____

[*Visa & MasterCard number appears as 3 digit number on the back of the card. American Express number appears as a 4 digit number printed on the front of the credit card after and to the right of the card number.]

Expiration Date: _ _ / _ _

Cardholder's Signature: _____ Date: ___ / ___ / ___

NON-COVERED SERVICES WAIVER

I understand that charges for my care will be filed with my insurance carrier as a courtesy by **North Florida**. There may be a service that I desire that is not covered under my insurance plan ("Non-Covered Services"). I understand that I will be financially responsible for the cost of any Non-Covered Services. A separate waiver will be completed for each Non-Covered Service. If I have Medicare, I will complete an Advance Beneficiary Notice ("ABN") form.

INSURANCE WAIVER

I understand that if I do not have a copy of a current insurance card and valid referral, if required, that I can be seen as a "Private Pay" patient. I agree that neither **North Florida** nor I will file a claim for the visit. A waiver will be completed for each visit that I am seen as a Private Pay patient. I will be required to pay the total cost of the visit in advance.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to **North Florida**. I hereby authorize **North Florida** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

ASSIGNMENT OF MEDICARE BENEFITS

I hereby authorize and assign all payments of authorized Medicare benefits for medical services and/or surgical procedures rendered to patient, directly to **North Florida**. I hereby authorize **North Florida** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by Medicare for which I have signed an ABN.

ARBITRATION

THIS ARBITRATION AGREEMENT is made between **North Florida Surgeons, P.A.**, for and on behalf of itself and its subsidiaries, affiliated professional associations, physicians (including physicians providing medical services through a subsidiary of North Florida Surgeons, P.A.), agents, employees, servants, or any of the foregoing, referred to hereinafter as "Doctor" and the above referenced patient ("Patient"). It is the intention of the parties to this Arbitration Agreement to bind not only themselves, but also their heirs, personal representatives, guardians and any persons deriving claims through or on behalf of the patient.

It is understood by the Patient that he or she is not required to use **North Florida Surgeons, P.A.** or any Doctor and that there are numerous other physicians located near Patient who are qualified to provide care to Patient.

In the event of any controversy or dispute, which might arise between Doctor and the Patient, regardless of whether the dispute concerns the medical care rendered, including any negligence claim relating to the diagnosis, treatment, or care of the Patient, or payment of surgical fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Federal Arbitration Act, 9 U.S.C. §§ 1-16.

Other than what may be in conflict with this Arbitration Agreement, the laws of the State of Florida shall apply to any dispute between Doctor and the Patient. The Florida Rules of Civil Procedure shall apply for discovery purposes only.

Prior to commencing any action under this Arbitration Agreement, Patient must comply with the presuit notice and investigation requirements of Chapter 766, Florida Statutes. Any arbitration under this Arbitration Agreement must be commenced by the filing of an application for arbitration within the applicable statute of limitations for the controversy or dispute at issue.

This arbitration shall be in lieu and instead of any trial by Judge or Jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. All arbitrators shall be selected from the following Florida counties: Alachua, Clay, Duval, Nassau, St. Johns and Volusia. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties and may be enforced by a court of law if necessary. Arbitration shall be conducted in Duval County, Florida.

In the event that either party to this Arbitration Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, including the appointment of the arbitrator and hearings to resolve the dispute, despite the refusal to participate or the absence of the opposing party. The arbitrators shall render a binding decision without the participation of the party opposing arbitration or despite his or her absence at the arbitration hearing.

ARBITRATION - Continued

Except for legal reporting requirements, all arbitration proceedings and outcomes under this Arbitration Agreement will be confidential and private. The parties shall be required to attend non-binding mediation in Duval County, Florida prior to arbitration.

The Patient understands that the Patient has a constitutional right under Article 1, Section 21 of the Florida Constitution of Access to Courts as follows: "The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay." The Patient understands and acknowledges that signing this Arbitration Agreement waives this constitutional right.

Should any sentence(s) of this Arbitration Agreement be declared unenforceable or in conflict with the law, the sentence(s) shall be severed and the validity of the remaining parts and provisions shall not be affected by such holding.

The Patient has had an opportunity to read this Arbitration Agreement, or to have it read to him or her if necessary. The Patient understands English or has had this Arbitration Agreement translated for him or her by _____. The Patient has had an opportunity to ask questions about this Arbitration Agreement. The Patient understands this Arbitration Agreement and has no unanswered questions.

Patient Initials: _____

ARBITRATION - Continued

The Patient has not been coerced or compelled to sign this Arbitration Agreement, and does so of his or her own free will. The Patient may consult with an attorney before signing this Arbitration Agreement.

BY SIGNING THIS ARBITRATION AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE TERMS AND CONDITIONS.

Patient Signature: _____ **Date:** _____

Parent, Guardian or Legal Representative Signature: _____

Relationship to Patient: _____

Witness Signature: _____

Physician Signature: _____

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED IN THIS AGREEMENT.

Patient Signature: _____ **Date:** _____

Parent, Guardian or Legal Representative Signature: _____

Relationship to Patient: _____

Witness Signature: _____