Ideal Family Healthcare, P.C.

Patient Billing Agreement:

I acknowledge the following by my signature below:

1. I verify that I have reviewed my insurance information listed with Ideal Family Healthcare, P.C., and that it is correct. I understand that if my insurance claim is denied due to incorrect personal information or incorrect insurance information that I have provided, I will be billed and the payment in full will be due immediately.
2. I verify that I have designated either Dr. Heather Sharp MD, or Dr. Gregory Sharp MD of Ideal Family Healthcare, P.C. as my primary care physician with my insurance plan. I understand that if my insurance company denies paying my claim for a visit because it s determined that either Dr. Sharp was not my designated PCP in effect at the time of my visit, that I am responsible for paying in full for all services rendered.
3. If I have insurance that Ideal Family Healthcare, P.C. is contracted with, I authorize assignment of payment directly to Dr. Heather or Greg Sharp MD for services provided to me. I understand that Ideal Family Healthcare, P.C. will file a claim with my insurance company and that I am responsible for following up with my insurance company to insure my claim is paid within 60 days of my visit date.
4. I understand that if I have a PPO insurance plan, and my insurance has not paid my claim within 60 days of my visit date, that the charges for the visit date will become my responsibility to pay.
5. I understand that, under the terms of the contract that I have with my insurance company, I must pay any pre-determined co-payments at every visit.
6. If I have insurance with which Ideal Family Healthcare, P.C. has not contracted I agree to pay my bill in full at the time services are provided. I understand that I may request appropriate documentation of services provided by Ideal Family Healthcare, P.C. but that it is my responsibility to submit any such documentation and seek reimbursement from my insurance company. I understand that Ideal Family Healthcare, P.C. cannot act as an intermediary between me and my insurance company to effect payment.
7. If I am a patient with no insurance coverage, I agree to pay my balance in full at the time services are rendered.
8. I understand that Ideal Family Healthcare, P.C. may apply finance charges to any balance that is outstanding greater than 90 days, and that if I carry an unpaid balance for longer than 120 days, I will no longer be able to access the services of Ideal Family Healthcare P.C.. I further understand that Ideal Family Healthcare, P.C. may turn over any unpaid balances after 120 days to a collection agency to effect payment and that such action may affect my personal credit score.
9. I hereby request and authorize Ideal Family Healthcare, P.C. physicians and personnel to deliver medical care to myself or my dependents.
10. I understand that medical records are the property of the physician of Ideal Family Healthcare, P.C.; however, I am entitled to a copy, with sufficient advanced notice, upon my written request (patients aged 18 and older must sign their own medical record release form). I understand that there may be a charge for copies of my medical records.
11. I hereby authorize the release of medical information to my insurance company concerning any illness and treatment.
12. I acknowledge that I can obtain a copy of Ideal Family Healthcare's Privacy Practices/Patient's Privacy Rights upon request.

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Signature of Patient or Legal Guardian Date

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Print Patient's Name Print Name of Legal Guardian, if applicable