ProHealth
Family Physicians
3100 17th Street • St. Cloud, FL 34769
PH 407-892-0009 • 407-892-3285 FX

Financial Policy Agreement, Assignment of Benefits and General Authorizations

Read this Agreement Carefully: You are agreeing to financial terms and you may request a copy. I accept the terms of this agreement to avoid misunderstandings concerning the payment of fees for services provided to me. I understand that ProHealth Family Physicians employees are not authorized to make exceptions to this agreement.

Appointments: I agree to make every effort to keep my appointments and to contact the office at least 24 hours in advance if I cannot do so. If I no show for my appointment or I do not cancel my appointment with at least 24 hours notice I will be charged a fee of $25.00.
Appointments for Urodynamics, Pelvis Floor Rehabilitation and Stress Testing have a separate cancellation/no show policy and will require a separate signature when you schedule an appointment for them.

Deductibles, Copays and Account Balances: I agree to make full payments of deductibles, copayments or any balance on my account before I leave the office. Unless I have spoken to a representative from the billing department and a different arrangement has been made.

Insurance and Patient Financial Balances: I understand that my health care plan is a contract between me and my plan and that I am responsible for the entire bill regardless of what my insurance pays. ProHealth Family Physicians will bill my insurance company if I assign insurance benefits to ProHealth Family Physicians. I understand that all health care plans are not the same and may not cover the same services or all of my services or charges. I understand that fill payment for my treatment remains my exclusive financial responsibility and I will promptly pay any amounts that are not paid by my insurance company/companies within a reasonable time determined by the practice. I agree to make payment in full upon receipt of a statement from ProHealth Family Physicians. I understand that ProHealth Family Physicians is not an agent of any insurance company and cannot make representations regarding my coverage. I understand that verification of insurance coverage is my sole responsibility. I am satisfied with my insurance plan coverage of charges and I will pay all charges not paid by my insurance including lab charges.

Assignment of Benefits: I authorize ProHelath Family Physicians to act as my agent to help obtain payment from my insurance companies and request and assign payment directly to ProHealth Family Physicians by all insurance companies with whom I have coverage or from whom benefits are or may become payable to me including settlements of judgments flowing from incidents for which I may receive treatment.

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Insurance, Labs and Patient Financial Responsibility: I am fully responsible for lab charges not covered by my insurance. I understand that my insurance company may require use of a particular lab company and that ProHealth Family Physicians neither chooses nor is an agent of those labs. I understand that insurance plans change lab participation frequently and it is my sole responsibility to inform ProHealth Family Physicians of the correct lab use. I understand that I am responsible for payment of any bill received from a lab and will contact the lab directly to resolve billing questions.

Minor Patients: I understand that for all services rendered to minor patients, the adult accompanying the patient will be required to make any co-payment, deductible, co-insurance or cash balance payments prior to service.

Copies of Medical Records: If I request copies of medical records, I agree to pay $1.00 per page for the first 25 pages of written material and $.25 for each additional page.

FOR MEDICARE PATIENTS: I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to ProHealth Family Physicians for any services furnished to me by ProHealth Family Physicians. I authorize any holder of medical information needed to determine these benefits payable for related services. I agree to execute such forms and documents as may be necessary to apply for and obtain payment.