PHA ADULT MEDICINE
DELIVERING THE CARE YOU NEED
1740 South Street, Suite 300, Philadelphia, PA 19146

PAYMENT POLICY

"I" collectively refers to the patient, his/her guardian and/or his/her surrogate decision maker.

Assignment to Pay Insurance Benefits

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare or its representative, private insurance, Medicaid and any other health plans or third-party payers to PHA-Adult Medicine. This assignment is for services rendered to me by PHA-Adult Medicine and its providers. This assignment will remain in effect until revoked by me in writing. A photocopy or electronic version of this assignment is considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment. PHA-Adult Medicine reserves the right to refuse said assignments.

My Responsibility to Pay Balance Due

I agree that if I am a cash paying patient, I am expected to pay full payment at time of service. If I have insurance, I agree to pay applicable co-pay at the time of service. If my deductible has not been met, PHA-Adult Medicine will collect a portion of the office visit and submit claim to my insurance. Even though insurance will be filed, I agree to pay all charges not covered by my insurance and which are determined to be my responsibility. I agree that PHA-Adult Medicine will supply a statement of balance owed and I will pay within 30 days of date of such statement. If I am more than 30 days past due, I will be considered delinquent. If I have financial difficulty paying my bill, I will inform PHA-Adult Medicine of this and take advantage of payment plans or other agreement made to bring my account current. I also understand that while PHA-Adult Medicine values its commitment to serve me, it reserves the right to terminate the patient-physician relationship for delinquent account status not made current or for clear refusal to make payments. If termination is necessary, a 30-day notice will be given to find another primary care physician. During this time, PHA-Adult Medicine will provide care for medical emergencies only. PHA-Adult Medicine reserves the right to refer my account to a collection agency and I am responsible for collection fees.

In addition to the value of the check, there will be a $25 charge for bounced checks.

In addition, there are charges for completing forms to be used outside of the medical record: Examples: Utility forms, Employment Forms, School Forms, Disability Forms, Driver's Permit, Home & Community Based Services Waiver Forms, Handicap Permit Forms, Nursing Home Placement Forms.

Attestation

I acknowledge that I understand the above and any questions I may have had were answered to my satisfaction. I understand that a photocopy or electronically stored copy of this signed document is as valid as the original.

_____	_____	_____
Patient/Guardian/Surrogate Decision Maker	_ Signature	Date