EUDORA MEDICAL

Today's date

Patient NAME	Date of birth

LETTER OF FINANCIAL COMMITMENT

Failure to pay your copay: An administrative fee of $5.00 will be charged if you do not pay your co-pay at time of service.
Debit/credit card fee: I understand and agree to accept the responsibility of paying the credit card fee of _< 4_%.
Returned check fee: Checks returned unpaid by your bank institution will result in a minimum charge of $30.00 processing fee plus the original amount of the check. Future payments will only be accepted by cash or credit card.
Forms completion fee: Administrative fees for the completion of forms such as FMLA, ADA, social security, disability, health screens and special letters start at $10.00 per page and increase nominally depending on the complexity of the form(s). Please allow up to 72 hours for completion of such forms. If you should need forms completion to be expedited within 24 hours, there will be an addition fee of $25.

I HAVE READ, UNDERSTOOD AND AGREE TO THE OFFICE POLICY STATED ABOVE AND ACCEPT RESPONSIBILITY AS DESCRIBED.

Signature **Date**

AUTHORIZATION TO PROVIDE TREATMENT, INSURANCE ASSIGNMENT, RELEASE

I hereby authorize Eudora Medical Center LLC or any medical provider authorized by it, to provide such medical services, either regular or emergency, as may be determined by the medical provider to be in my best interest (or the best interest of my dependent if I am signing as a parent or guardian). Further, I hereby assign, transfer and set over to Eudora Medical Center LLC all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with the insurance policy (ies) listed in this registration packet or any other third party payor that may be responsible for the cost of the medical services rendered and agree to pay any and all amounts not paid by other within ninety days from the date billed unless there are other agreements between me or my insurance company and Eudora Medical Center LLC. I agree to pay all collection costs including, but not limited to bad check charges, court costs, witness expenses and reasonable attorney fees if it becomes necessary to turn this account over to an outside party for collections. These authorization and releases remain in effect until I choose to revoke them by delivering a written statement to Eudora Medical Center LLC.

Signature **Date**

MEDICARE PATIENT WITH MEDICARE SUPPLEMENTAL INSURANCE POLICIES

I request that payment of authorized Medicare supplement benefits be made on my behalf to Eudora Medical Center LLC for any services furnished me by that supplier. I authorize any holder of medical information about me to release to my Medicare supplement insurer any information needed to determine these benefits. This authorization is in effect until I choose to revoke it.

Signature **Date**

EUDORA MEDICAL

Today's date

FINANCIAL POLICY

Patient **NAME**:	Date of birth:

PAYMENT FOR SERVICE IS DUE IN FULL AT THE TIME SERVICE IS PROVIDED

For patients with insurance: We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 90 days of billing, professional fees are due and payable in full from you.

Medicare patients: We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided. As a Mississippi medical provider, we are unable to file Tennessee Medicaid of any kind.

Noncovered services: Any care not paid for by your existing insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial.

Missed appointments: In fairness to other patients, the medical staff and provider(s), we require a minimum of 24 hours' notice to cancel appointments. You will be charged $35 for missed appointments and may be dismissed from the practice after three missed appointments.

MEDICARE PATIENTS: SIGNATURE ON FILE

I request payment of authorized Medicare benefits be made either to me or on my behalf to Eudora Medical Center LLC, 8995 West Commerce Street, Suite 4, Hernando, MS 38632 for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (Please Print) **Patient's Medicare #**

ASSIGNMENT OF INSURANCE BENEFITS

Patients with insurances please read and sign below. I hereby assign al medical benefits to include major medical benefits to which I am entitled, private insurance and any other health plans to Eudora Medical Center, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand 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 the payment.

I HAVE READ, UNDERSTOOD AND AGREE TO ALL OF THE ABOVE FINANCIAL POLICY FOR PAYMENT OF PROFESSIONAL FEES. THE PATIENT IS ULTIMATELY RESPONSIBLE FOR ALL PROFESSIONAL FEES.

Signature **Date**