Health ONE® Cardiothoracic Surgery Associates
Physician Care℠

PATIENT NAME_____**DATE OF BIRTH**_____

PATIENT FINANCIAL AGREEMENT

1. _____**(Patient or Guardian Initials)**
Financial Agreement.
   - I acknowledge, that as a courtesy, **CARDIOTHORACIC SURGERY ASSOCIATES** may bill my insurance company for services provided to me.
   - I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
   - I understand that there is a fee for returned checks.

2. _____**(Patient or Guardian Initials)**
Third Party Collection. I acknowledge that **CARDIOTHORACIC SURGERY ASSOCIATES** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____**(Patient or Guardian Initials)**
Assignment of Benefits. I hereby assign to **CARDIOTHORACIC SURGERY ASSOCIATES** any insurance or other third-party benefits available for health care services provided to me. I understand **CARDIOTHORACIC SURGERY ASSOCIATES** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **CARDIOTHORACIC SURGERY ASSOCIATES,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____**(Patient or Guardian Initials)**
Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **CARDIOTHORACIC SURGERY ASSOCIATES** by the Medicare or Medicaid program.

5. _____**(Patient or Guardian Initials)**
Consent to Telephone Calls for Financial Communications. I agree that, in order for **CARDIOTHORACIC SURGERY ASSOCIATES**, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **CARDIOTHORACIC SURGERY ASSOCIATES** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **CARDIOTHORACIC SURGERY ASSOCIATES** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____**(Patient or Guardian Initials)**
A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient. (Circle or mark relationship(s) from list below):

__ Spouse
__ Parent
__ Legal Guardian
__ Guarantor
__ Healthcare Power of Attorney
Other (please specify)_____