FINANCIAL RESPONSIBILITY AGREEMENT

This Financial Responsibility Agreement ("Agreement") is a legally binding contract between you and Alyeska Family Medicine (AFM). This Agreement supersedes any and all prior agreements between AFM and you concerning payment of our charges, and applies to all future charges you may incur. Please read this document carefully and ask a member of our staff to answer any questions which you may have before you sign this document.

CHARGES DUE AT THE TIME OF SERVICE. All charges for our services are due at the time of service except as provided in this Agreement.

INSURANCE BILLING. If you are insured by a company for which AFM is a Preferred Provider, we will bill your insurance company in accordance with our agreement with your insurance company. Otherwise, we will bill your insurance as a courtesy only, and we reserve the right to stop doing so at any time. Whether or not we bill your insurance company, you are ultimately responsible for payment of all of our charges.

DEDUCTIBLES. If you know that you have not yet met your full insurance deductible at the time of service, you must pay the unmet portion of your deductible at that time, and we will bill your insurance company for the rest of our charges. If we bill your insurance company and any portion of our charges is not paid by your insurance company due to an unmet deductible, we will bill you for, and you must pay, such unpaid charges.

COPAYMENTS (Coinsurance) AND LIMITS ON COVERAGE. Even after you have met your full deductible, your insurance may not cover 100% of our charges. . If you know, or if we believe, that you have a copayment obligation or there are applicable limits on your insurance coverage, you must pay all copayment amounts and any other amounts not covered by your insurance at the time of service, and we will bill your insurance company for the rest of our charges. If we bill your insurance company and any portion of the charges is not paid by your insurance company due to a copayment amount or limit on coverage, we will bill you for, and you must pay, such unpaid charges.

USUAL & CUSTOMARY CHARGES. AFM sets its fees independent of any health insurance company or other organization. If you are insured by a company for which AFM is a Preferred Provider, we have agreed to accept what your insurance company considers usual and customary charges in payment for our services. If AFM is not a Preferred Provider for your insurance company, and if we bill your insurance company and any portion of our charges is not paid by your insurance company due on the ground that our charges exceed what your insurance company usual and customary, we will bill you for, and you must pay, such unpaid charges.

DUAL COVERAGE. If you have medical insurance from more than one source, AFM will, as a courtesy, bill your primary and secondary insurance, but we reserve the right to stop doing so at any time. We will not bill a third insurance under any circumstance. If we bill your secondary insurance, the above provisions concerning payment of deductibles, copayments, and other amounts will still apply. Whether or not we bill your secondary insurance, you will remain ultimately responsible for payment of all of our charges.

MOTOR VEHICLE INSURANCE. AFM will not, in any case, bill a motor vehicle insurance company. All charges for any care which you receive related to a motor vehicle accident must be paid at the time of service.

AFM will provide you with the necessary documentation so that you may be reimbursed from your motor vehicle insurance.

WORKERS COMPENSATION. If you are being treated for an illness or injury which is covered by Workers Compensation, you must bring the name of the Workers Compensation insurance company and your specific case number to your first visit. You will not be treated without this information. We will file a claim with the Workers Compensation insurance. If Workers Compensation insurance notifies us that any portion of your treatment is not covered, AFM will, as a courtesy, bill your regular medical insurance, if any, but we reserve the right to stop doing so at any time. If we bill your regular medical insurance, the above provisions concerning payment of deductibles, copayments, and other amounts not covered by insurance will still apply. Whether or not we bill your regular medical insurance, you will remain ultimately responsible for payment of all of our charges.

AUTHORIZATIONS & PROCEDURES. The decision to perform any medical testing or surgical procedure is entirely between you and your physician. However, in each case your insurance company will decide whether or not the service was covered by your policy. In the case where your insurance company does not cover a particular service, we will bill you for, and you must pay, all of the charges for that service. AFM does not seek preauthorization from insurance companies before providing services. Therefore, it is your responsibility to seek prior authorization from your insurance company should you need or wish to do so. Please be warned that prior authorization is not a guaranty that your insurer will pay for a particular service. You remain responsible for payment of all of our charges in any event.

SERVICE CHARGES. The below listed service charges will not be billed to any medical insurance company and must always be paid by you directly.

- A charge of $30.00 will be applied to checks returned to us due to non-sufficient funds in your bank account.
- A "no show fee" of up to $100.00 may be charged any time you miss an appointment, or cancel/reschedule an appointment with less than 24 hours notice.
- Interest charges, up to the amount allowed by law, may be added to the amount you owe if your account is overdue.
- If you do not pay your balance within a reasonable time and your account is sent to collections, you agree to pay the cost of collections in addition to the amount you owe. The cost of collections includes the fees of a collection agency and/or attorney fees and court costs. The fees of a collections agency may be 35 % or more of the amount you owe.

_____	_____
Name of Patient (Print)	Patient's Date of Birth
_____	_____
Signature of Patient	Today's Date
_____	_____
Name of Person Responsible for Payment	Relationship to Patient
_____	_____
Signature of Person Responsible for Payment	Today's Date

PRINT