# Financial Agreement

Client's Name: _____

Financially Responsible Party: _____

Relationship to Client: (Circle One) Self Spouse Parent Other _____

*FINANCIAL RESPONSIBILITY*: I, the undersigned, hereby agree to assume full responsibility for any and all charges for services rendered by *Andrea M. Jimenez, M.D*. to the above named client.

*ASSIGNMENT OF INSURANCE BENEFITS*: I hereby authorize and direct my insurance company or companies to make direct payment to *Andrea M. Jimenez, M.D*. under any and all applicable coverage, including major medical, for covered charges resulting from the services rendered by *Andrea M. Jimenez, M.D*. to the client named above.

*PAYMENT OF BALANCE DUE*: I will pay the full amount of charges for all services rendered that are not paid directly by my insurance company or credited in accordance with the requirements of my health care plan.

*CREDIT BALANCES*: Any credit balance on my account will be used to offset charges for future services for the above named client. Any credit balance remaining at the end of treatment will be refunded to me.

*AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION*: In compliance with HIPAA, authorization is hereby given to release to my health care plan or insurance company, or to any of its contracted/designated agents, any and all medical information essential to certify the medical necessity and appropriateness of services rendered, and/or to process any claim for reimbursement of charges incurred for services rendered or for the purpose of determining continued eligibility and/or audit for quality of care.

*DELAY OF PAYMENT*: If full payment is not received in 120 days, the undersigned shall be in default. Interest will be added to the outstanding balance at the rate of 18% annum (1.5% per month) on the total outstanding balance. Accounts in default may be referred to a collection agency.

I, THE UNDERSIGNED HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FINANCIAL AGREEMENT REGARDING ASSIGNMENT, AUTHORIZATION, AND DELAY OF PAYMENT. I UNDERSTAND THAT SHOULD MY ACCOUNT BE DEFAULT, CERTAIN ITEMS OF MY PROTECTED HEALTH INFORMATION MAY BE DISCLOSED FOR THE PURPOSES OF COLLECTION. I HEREBY AUTHORIZE AND CONSENT TO THE TERMS INDICATED.

_____ _____

*Signature* *Date*

_____

*Name Printed*