Arnold Graham Smith, MD, PA

Spine Evaluation and Rehabilitation

9191 R. G. Skinner Parkway, Suite 103
Jacksonville, FL 32256
Phone: (904) 391-6862 Fax: (904) 391-1005

Financial Responsibility and Office Policy Agreement

Read Carefully, if you have any questions feel free to ask!

I understand that:

♦ I am solely responsible for payment of services provided to me by the Healthcare Professionals at the office of Arnold Graham Smith, MD, PA. (unless covered under Worker's Compensation)

♦ I will pay for services at the time they are provided to me unless I have made other arrangements with the office staff. Payment arrangements can be made for large balances by signing an installment agreement form.

♦ Fees for services will be filed with my insurance company on my behalf as a courtesy provided by Arnold Graham Smith, MD, PA, and I am responsible for any service that my carrier determines to be my responsibility in a reasonable time period (60 days).

♦ I will pay all deductibles and copays required by my contractual agreement with my insurance carrier at the time of service.

♦ If I have not notified the office 24 hours in advance, I will be charged $30.00 for any appointment that I do not keep. We recognize that true emergencies and scheduling conflicts do arise. (**Although it is our policy to confirm appointments, you are ultimately responsible for remembering your appointment day and time. We will provide an appointment card for you at the time you schedule follow up or therapy appointments)**

♦ There will be a **minimum** charge of $10.00 for completion of all forms.

♦ There will be a charge of $20.00 for all returned checks. Replacement checks will **not** be accepted. We will accept cash, credit card, cashier's check, or money order.

♦ **I am responsible for notifying the office of any changes in my insurance status, mailing address or phone number.**

♦ If I default on my account, I am responsible for all fees associated with collections.

A copy of this agreement will be as valid as the original.
I have read and understand this Financial Agreement thoroughly.

Patient Signature: _____ Date: _____