

Sherwood Family Medicine

Financial Agreement

Date: _____

Patient Name: _____

Patient Date of Birth: _____

I authorize Sherwood Family Medicine to provide to my insurance companies all information necessary to process insurance claims and assign Sherwood Family Medicine all of the insurance benefits due to me to the full extent of my financial obligation.

I understand that I am ultimately responsible for my balance with Sherwood Family Medicine if my insurance does not pay or for whatever portion is deemed patient responsibility.

I understand that when I receive a statement from Sherwood Family Medicine this is my responsibility and I am required to pay in full all balances due or to call to make payment arrangements.

On balances due over \$150.00 we allow a 4 month payment plan.

If your balance ages over the 4 month period, Sherwood Family Medicine reserves the right to charge 5% interest on the balance each month, or a \$5.00 statement fee, whichever is greater.

Date: _____

Patient Signature: _____

Signature of Patient's Representative: _____

(If patient is under 18)

Relationship of Representative: _____