Peninsula Nephrology Associates P.A.
Financial Agreement

Date

Patient Full Name | Date of Birth | Home Phone #

Physical Address | City, County | State | Zip | Cell Phone #

Mailing Address | City, County | State | Zip | SS #

Employment | Yrs | Employer's Phone

Employer's Mailing Address

I authorize Peninsula Nephrology Associates, P. A. to apply benefits on my behalf for services rendered. I request payment from my insurance company to be made directly to Peninsula Nephrology Associates, P. A. I certify that the information I have provided with regard to my insurance coverage is correct and future authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this be used in place of the original. I may revoke this right at anytime as long as I place it in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided when a statement is rendered.

The undersigned declares that he/she is duly authorized to enter into this agreement on behalf of Peninsula Nephrology Associates P. A. and that the following payment terms shall apply to all applicants future transactions with Peninsula Nephrology Associates P.A. Our regular billing date is on or about the first business day of each month; unless there is a balance after an insurance payment has been posted. Peninsula Nephrology Associates P. A. will send out a billing statement and payment is due within 30 (thirty) business days of receipt. If your account is not paid within the 30 (thirty) days, your account is past due and in default. Peninsula Nephrology Associates P. A. has the right to add a late payment fee of $10.00 per month and will accrue monthly on an unpaid balance. In the event this account is placed in the hands of an attorney for collection or if suit is filed to collect same or portion thereof, any and all fees will be added to the account and will become your responsibility.

If payment is not made as agreed upon, the account will be turned over for collection. The patient, and/or guarantor, shall be responsible for and agree to pay actual costs for collection including, but not limited to collection agency fees, attorney's fees, court cost, and all fees incurred for serving court documents. If any suit must be filed to collect an unpaid balance, patient, and/or guarantor, agrees that each of them is individually, jointly, and generally liable for any delinquent balance, and that such may be brought in the courts of Wicomico County, Maryland, and waives any objection to jurisdiction or venue.

Patient/Guarantor (Sign and Print) Date