STEVEN E. GOODWILLER, M.D., P.A.

DIPLOMATE OF THE AMERICAN BOARD OF ORTHOPAEDIC SURGERY

FINANCIAL AGREEMENT

READ CAREFULLY

As a courtesy to you, the patient/insured party, Dr. Goodwiller has agreed to file any claims for charges on your behalf to your insurance carrier. It is **YOUR RESPONSIBILITY** to pay your deductible, co-payment, and co-insurance and any other balance not paid by your insurance company. **ANY COPAYS, CO-INSURANCE or DEDUCTIBLES** shall be paid at the time the services are rendered. **NO EXCEPTIONS!!!** Your insurance is a contract between you and your insurance carrier. It is your responsibility to provide our office with current filing information, verify that Dr. Goodwiller is a provider for your insurance plan, and to keep any needed referrals current. Failure to do so may necessitate your payment of otherwise covered services. Please be aware that some of the services provided may be non-covered services or not considered reasonable and necessary under the Medicare program and/or other medical insurance.

MINOR PATIENTS

A parent or legal guardian must be present at the time of the office visit. No one under the age of 18 will be treated without a parent or legal guardian present. A parent or legal guardian, who by signing below, gives Dr. Goodwiller permission to treat the minor child and will accept financial responsibility for services rendered.

CASH PATIENTS

By signing below, I agree to pay for services rendered to me in FULL on the date of the visit. All fees are expected at the time of service. This office does offer financing if needed. If for any reason your account has a balance and is not paid in full within 30 days, your account will incur a 1% finance charge for any amount over $50.00 and $1.50 finance charge for any amount under $5.00.

COLLECTION POLICY

After the balance is transferred to patient responsibility and statements are sent for 90 days with no response, the account will be turned in to our collections firm for further collection activity. In the event that your insurance company sends the payment to you, by signing below, you agree to sign over the check to Dr. Goodwiller for payment on your account.

CONSENT TO TREAT

By signing below, I authorize Dr. Goodwiller to treat me: I have read, understand and agree with this financial policy. **THIS IS A LIFELONG SIGNATURE.**

Signature of Patient or Responsible Party ______ Social Security # ______ Date Signed ______

402 W. 19TH STREET, PANAMA CITY, FL 32405 TEL 850.763.6179 FAX 850.763.0412