West Florida Primary Care
- Nine Mile Road
- Immediate Care
- Pediatrics
- Pace
- Pine Forest
- Spanish Trail
- West Pensacola
- W Street
- Avalon

West Florida Medical Group

West Florida Specialty Physicians
- General Surgery
- CV Surgery
- Cardiology
- Orthopedic Surgery
- Obstetrics/Gynecology
- Neurology

West Florida Behavioral Health
West Florida Internal Medicine

PATIENT FINANCIAL AGREEMENT

1. **_____(Patient or Guardian Initials)**
Financial Agreement.
   - I acknowledge, that as a courtesy, **WEST FLORIDA MEDICAL GROUP** may bill my insurance company for services provided to me.
   - I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
   - I understand that there is a fee for returned checks.

2. **_____(Patient or Guardian Initials)**
Third Party Collection. I acknowledge that **WEST FLORIDA MEDICAL GROUP** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. **_____(Patient or Guardian Initials)**
Assignment of Benefits. I hereby assign to **WEST FLORIDA MEDICAL GROUP** any insurance or other third-party benefits available for health care services provided to me. I understand **WEST FLORIDA MEDICAL GROUP** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **WEST FLORIDA MEDICAL GROUP,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. **_____(Patient or Guardian Initials)**
Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **WEST FLORIDA MEDICAL GROUP** by the Medicare or Medicaid program.

5. **_____(Patient or Guardian Initials)**
Consent to Telephone Calls for Financial Communications. I agree that, in order for **WEST FLORIDA MEDICAL GROUP**, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **WEST FLORIDA MEDICAL GROUP** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **WEST FLORIDA MEDICAL GROUP** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. **_____(Patient or Guardian Initials)**
A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify)_____