HARBOR PHYSICIANS
Primary Care & Internal Medicine

2140 Kingsley Ave, Suite 1, Orange Park, FL 32073
Ph: 904-368-6809 | Fax: 904-368-6809

Patient Name: _____ DOB_____

FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

1. Insurance and Appointment Requirements

I understand that it is my responsibility to provide valid insurance information, referral authorization (if required), and applicable copayment at the time of service. Failure to provide required documentation or payment may result in rescheduling or cancellation of my appointment.

2. Copayments and Time-of-Service Payment

I agree to pay all copayments, coinsurance, and any patient-responsible balances at the time of my visit unless prior arrangements have been made.

3. Returned Payments and Administrative Fees

A fee of $25.00 will be charged for any returned or declined payment, including returned checks or failed electronic payments, as permitted by applicable law.

4. Missed Appointments / No-Shows

I understand that missed appointments or late cancellations may result in a no-show fee, and repeated missed appointments may affect my ability to continue care with this practice.

5. Insurance Billing and Patient Responsibility

I authorize this practice to bill my insurance carrier directly. I understand that insurance coverage is a contract between me and my insurance company, and I am financially responsible for all charges not covered by insurance, including deductibles, copayments, coinsurance, and non-covered services.

6. Delinquent Accounts and Collections

Accounts not paid in a timely manner may be referred to a third-party collection agency. I agree to be responsible for all costs of collection, including reasonable collection fees, attorney fees, and court costs, if applicable.

7. Assignment of Benefits

I authorize payment of medical benefits directly to Harbor Physicians for services rendered. This authorization remains valid until revoked in writing.

8. Eligibility Certification

I certify that I am eligible for insurance benefits at the time services are rendered. If this certification is incorrect, I understand that I am financially responsible for all charges incurred.

9. Payment Agreement

I agree to pay any outstanding balances within 30 days unless other arrangements have been approved in writing by the practice.

Patient Signature: _____Date: _____

Staff Witness: _____

Date: _____