Banner Health®

FINANCIAL AGREEMENT FOR BANNER MEDICAL GROUP

I agree that in return for the services provided to me or the patient (if a different person – hereafter the word patient applies to both of us) by Banner Medical Group or other health care providers at the clinics or providers affiliated with Banner Medical Group, I will pay the account of the patient and/or make financial arrangements satisfactory to Banner Medical Group. Unless the patients' bill is paid by applicable insurance, government programs or other sources, I agree to pay Banner Medical Group's usual and customary charges, which are those rates filed annually the State's Department of Health Services. If an account is sent to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses in addition to the amount due and owing on the bill for health services rendered to the patient if I am ultimately found to be liable for the bill. I understand and agree that a delinquent account will be subject to interest at the legal rate.

Estimated charges may be given at or before the time of service, but I understand that this is merely an estimate, based upon information that is available at the time and that the actual amount that the patient will be charged for medical services rendered may be different from the estimate of charges for a variety of reasons, including but not limited to, additional procedures, tests or supplies that were not covered in the estimate.

I understand and agree that my insurance and/or the patients' insurance, if any, will be billed for medical services rendered to the patient, and payment from the insurer will be sought by Banner Medical Group before I am required to make payment (with the exception of applicable copayments, deductibles and coinsurances, which I must pay). I understand and agree that I am responsible for and I will pay for medical services rendered to the patient in the event that our insurance does not authorize these services or does not pay for all or any of these services. I further understand and agree that as part of the normal business communication with Banner Medical Group with regard to this matter, Banner Medical Group staff or representatives may contact me through any of the following methods: letter, email, telephone, text or voice messages, or any other available technologies used by businesses for such communications.

If the patient or I am entitled to benefits of any type whatsoever, under any policy of health or liability insurance, or from any other party liable to the patient, that benefit is hereby assigned to Banner Medical Group and/or to the providers rendering services, for application toward the patient's bill. I authorize the release of any medical information necessary to process claims and direct payment of benefits from my insurance company. It is understood and agreed, however, that the patient and I are primarily responsible for payment of the patient's bill and that we are obligated to pay and agree to pay for any portion of the bill that is not paid for by insurance or other sources. If I am an employee of Banner Health, I authorize Banner to deduct from my paycheck past-due amounts that I owe to Banner providers for health care services provided to me or my dependents enrolled in the Banner Health Medical plans. I understand that I may revoke this authorization at any time by notifying Employeeinquiry@BannerHealth.com.

In the event that the patient and/or I have a payment on an active account, whether through cash, check, credit card or other means, and there remain additional funds available after that account is satisfied (e.g. an overpayment), Banner Health is authorized to apply the overpayment to any other account owed by the patient that remains unpaid.

I have received my Medical Treatment Agreement. This includes my email and phone communication preferences.

_____ _____

Patient/Authorized Representative Relationship

_____ _____

Witness Date/Time

_____ (Printed Patient Name)

10020019 Registration