Keith P. Smith, M.D., F.A.C.S.
General Surgery
A.B.S. Certified 1985 • Recertified 1995, 2005, 2015

901 Leighton Avenue Suite 705, Anniston, AL 36207
PHONE (256) 231-1322 • FAX (256) 231-1324
OFFICE EMAIL: SmithMDOffice@cableone.net

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for allowing **Dr. Keith P. Smith** to provide you with the care you need. In the interest of good health care practices, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health, and we wish to spend our time and energy toward that end. Our goal is to make the financial aspect of your recovery as stress-free as possible.

As a courtesy to you, we will bill your insurance. If there are changes in your insurance, please let us know immediately so we can submit your claim properly. We cannot accept responsibility for collecting on an insurance claim after 60 days or for managing a disputed claim. You are responsible for any charges, or portions of charges that your insurance does not pay.

Co-pays are due at the time of service. You will begin receiving monthly statements with any balances after your insurance company has been billed. If you have any questions about your charges or statement, please contact our office at (256) 231-1322. The balance of the account is due within thirty (30) days.

Please contact the clinic if you are not able to keep your scheduled appointment. Appointments should be cancelled at least 24 hours in advance. An administrative fee in the amount of $25.00 may be incurred if appointments are not cancelled within this timeframe. We will use fair and reasonable discretion in applying this fee to any account.

(PLEASE CHECK ONE OF THE FOLLOWING)
I, the undersigned,:

- ☐ **have insurance coverage.** I authorize direct payment from my insurance carrier to Dr. Keith P. Smith.
  NOTE: You are responsible for knowing your coverage and benefits, which includes obtaining any referrals required. Our office will make every effort to inform you if a supply or service is not covered by insurance.

- ☐ **do not have insurance coverage.** I understand that I am financially responsible for payment of all charges.

I HAVE READ THIS CREDIT POLICY AND UNDERSTAND THAT REGARDLESS OF MY INSURANCE COVERAGE OR LACK THEREOF, I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT. IN CONSIDERATION OF SERVICES RENDERED OR TO BE RENDERED, THE UNDERSIGNED AGREES TO PAY ALL COSTS OF COLLECTIONS AND/OR REASONABLE ATTORNEY'S FEES SHOULD THE ACCOUNT BE TURNED OVER TO ENFORCE COLLECTION OF UNPAID ACCOUNT BALANCES.

PRINT PATIENT NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

(Patient is under 18 years of age)
PRINT PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

***Please ask the receptionist if you wish to have a copy of this form.**

Revised 05/03/16