PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing NC Elder Care as your healthcare provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, and patient billing. By signing below and/or by receiving medical services from NC Elder Care you agree:

1. You acknowledge and agree to the established policies and procedures NC Elder Care, including but not limited to this PATIENT FINANCIAL RESPONSBILITY STATEMENT.

2. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier or our policies, which are not otherwise covered by supplemental insurance.

3. You are responsible for knowing your insurance policy and providing insurance information to NC Elder Care.

4. By signing below, you authorize NC Elder Care to verify your insurance benefits and submit your claim to your insurance carrier or other plan provider. You agree to facilitate payment of claims by contacting your insurance carrier or other plan provider when necessary. Without waiving any obligation to pay, you assign to NC Elder Care, for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. You authorize NC Elder Care and associated physicians, staff, and hospitals to release patient information acquired in the course of your examination and/or treatment including but not limited to any and

all medical records, notes, test results, x-ray reports, MRI reports or other documents related to your treatment (including itemization of any charges and payments on my account) that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they require to participate in your care. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you may be responsible for the balance of the claim. NC Elder Care does not accept responsibility for incorrect information given by you or your insurance carrier or other plan provider regarding your insurance benefits or benefit plans.

5. **Authorization to Contact.** You authorize NC Elder Care personnel to communicate by mail, answering machine messages, and/or e-mail according to the information provided in your patient registration information. NC Elder Care, or any agent or servicer of your patient account, may use any information you have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers, to contact you for purposes related to your account, including debt collection. You authorize Medical Associates to use this information in any manner consistent with the information you have provided, including mail, telephone calls, e-mails, or text messages. You expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages.

6. Financial Responsibility Party. If this or a separate Medical Associates Financial Responsibility Statement is signed by another person, on your account, then that co-signature remains in effect until cancelled in writing. Cancellation in writing shall become effective the date after receipt, and shall apply only to those services and charges thereafter incurred. By signing as Financial Responsibility Party, you hereby guarantee the full and prompt payment to Medical Associates of all indebtedness of Patient to Medical Associates, whether now existing or hereafter created (the "Indebtedness"); and you further agree to pay all expenses, legal or otherwise, incurred by Medical Associates in collecting the Indebtedness, in enforcing this guaranty, or in protecting its rights under this guaranty or under any other document evidencing or securing any of the Indebtedness. This guaranty shall be a continuing, absolute and unconditional guaranty, and shall remain in force and effect until any and all said Indebtedness shall be fully paid. There shall be no obligation on the part of Medical Associates at any time to first exhaust its remedies against Patient,
7. Any other party, or any other rights before enforcing the obligations of Financial Responsibility Party.

Acknowledgement By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the Medical Associates Clinic, P.C. PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to Medical Associates for the below Patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report. I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original. ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

_____

Patient/Responsibility Party/Guardian Date

Witness _____

Patient/Responsibility Party/Guardian Date Date of Birth

Witness Waiver of Patient Authorizations I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

_____