RIVER ROAD MEDICAL GROUP

2026 Financial Agreement & Consent to Treat

The following paragraphs detail your financial responsibility and consent to treat with River Road Medical Group:

Financial Agreement: I, the undersigned, agree, whether I sign as an agent or as patient, that in consideration of the medical services rendered to the patient, I hereby individually obligate myself to pay the account of River Road Medical Group. I understand that a payment at the time of service is required on all new accounts unless covered by insurance. If my insurance is a co-pay plan, I understand that this is due time at time of service. It is my responsibility to provide correct and updated insurance information at each appointment.

Statements: I understand electronic statements will be sent out, and I will have access to pay and view my statement online via my patient portal. Paper statements are only available on request.

Finance Charge: A $5.00 finance charge may be assessed to all accounts older than 60 days that will be patient responsibility.

Insurance benefits: I, the undersigned, hereby authorize payment directly to the River Road Medical Group of the group or personal benefits or any other insurance benefits otherwise payable to me for the medical services rendered by the clinic.
-We participate with a variety of insurance plans. It is the patient's responsibility to ensure that our office is in-network with their insurance plan. Patients must provide valid insurance information at each visit and inform the office of any changes to their coverage. We will file claims on your behalf, but you are responsible for any portion not covered by insurance (i.e., deductibles, co-insurance, co-pays, or non-covered services).
-It is the patient's responsibility to understand the terms of their insurance plan, including any pre-authorization requirements, coverage limitations, or non-covered services.

Uninsured policy: A $50 deposit will be due at the time of scheduling and will be applied to your balance on the day of your appointment. If you do not show or cancel your appointment with less than 24 hours' notice, this is not refundable. River Road Medical Group will be providing a discount of 20% off our regularly priced professional fees if paid in full before or on day of services are rendered. If a payment plan is needed, the discount is no longer valid.

No Show/late cancellation fee: A $50 fee will be added to your account if you miss your appointment or cancel with less than 24 notice. Some exemptions apply. If you are unsure if you should keep your appointment or cancel, please call us to discuss it.

Patient Certification, Authorization to Release Medical Information: I, the undersigned, authorized the River Road Medical Group to release any medical information that may be necessary to request claim reimbursement from insurance companies or other payers to whom claims have been submitted, and to release credit information to appropriate gathering agencies.

Collection Fees: I, the undersigned, agree that if payment on this account is not made in accordance with the above-mentioned terms, I will pay reasonable attorney's fees and other costs incurred for collection.
- Accounts with outstanding balances of more than 90 days may be sent to a collections agency if payment arrangements have not been made.

Consent to Treat: I, the undersigned, authorize the physicians of River Road Medical Group, as well as other physicians who may be consulted regarding medical advice and treatment, to provide any medical

or surgical care which, in the opinion of the physician(s), may be reasonably necessary for the benefit of the patient's care.

I hereby authorize the above-named clinic to furnish the insured's insurance company with all information it may request concerning my medical care. I hereby assign to the provider(s) all money to which I am entitled for expense(s) relative to the services performed from time to time, but not to exceed my indebtedness to said provider(s). I understand I am financially responsible to said provider(s) for charges not covered by this agreement.

_____	_____
Printed Patient Name/Responsible Party	Relationship to Patient
_____	_____
Signature of Patient/Responsible Party	Date