Horizon Family Medicine, PA

www.horizonfamilymed.com

# PROMISSORY NOTE

**PLEASE CHOOSE YOUR PAYMENT SOURCE**

Legal Name (First, Middle, Last): ______________________________________ Date of Birth: ______________________

***PRIVATE PAY***

I, ________________________________________________________am acknowledging that I am a self paying patient seeking medical attention. I agree to pay my balance in full at the time of service or to pay 50% of my balance now and the remainder in full within 30 days or I will agree to a payment arrangement with the Billing Office before leaving the building and satisfying my agreement before my next scheduled visit.

***INSURANCE***

I, _________________________________________________________acknowledge that my claim will be sent to my insurance carrier for reimbursement. I will be responsible for the remaining balance (if any) in accordance with my insurance plan. Such payments will be paid within 30 days of receipt of statement or I will contact the Billing Office to make payment arrangements.

***WORKMANS COMPENSATION***

I, ___________________________________________________________acknowledge that a claim will be filed with my workman compensation carrier. If my claim is denied, I will be responsible for all charges on the account. Such payments will be paid within 30 days of receipt of statement. It is my responsibility to supply Horizon Family Medicine with the information needed to process any and all claims.

***PERSONAL INJURY***

I, ____________________________________________________________acknowledge that a claim will be filed with my attorney, private insurance and/or claim adjustor. I will be responsible for all claims if payment is not received within 30 days. Such payments will be paid upon receipt of statement. It is my responsibility to supply Horizon Family Medicine with the information needed to process any and all claims.

__________________________________________________________ ________________________________

**Signature of Patient (or Legal Guardian)** **Date**