PONTE VEDRA CONCIERGE MEDICINE

FINANCIAL AGREEMENT

Patient's Full Name:	
Patient's Date of Birth:	

*If you provide your e-mail and/or cell phone to us, we may use such information to contact you by email and/or text for appointment reminders, waiting lists, missed appointments and marketing of services provided by Ponte Vedra Concierge Medicine (the "Practice").

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay applicable membership fee to be paid monthly.

Payment may be made to the Practice in the form of Cash, Check, Debit and Credit Cards.
I understand additional charges ($40) are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account. I may also be charged if I do not cancel my scheduled appointment, or for not paying my membership responsibility within ten (10) days.

COLLECITON AND REFUND POLICY AND DISCHARGE FROM PONTE VEDRA CONCIERGE MEDICINE

Patients who do not pay their membership dues within 10 days of their monthly membership fees will have their account placed on hold and discharged from the practice with a 30 days' notice to seek care.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient's Signature*

Date*

Parent, Guardian or Legal Representative*