HealthNow Family Practice, LLC

"Better health now & wellness for life"
2086 Gulf to Bay Blvd • Clearwater, FL 33765. Phone: (727)462-0100 • Fax: (727)462-0177
7599 Park Boulevard • Pinellas Park, FL 33781. Phone: (727)999-2076 • Fax: (727)999-2078

"HEALTHNOW CARE PLAN"

12 MONTHS CONTRACT WILL INCLUDE:

1. 12 visits Per Year.
2. 1 Physical Exam including EKG/Pap smear.
3. Labs Discount up to 70%.
4. Free in house labs included: Hermoglobin Aic, Strep, Influenza, UA, Hemoglobin/Hermacrit
5. Free EKG 1 time per year or in house X-Ray maximum 3 times per year.
6. Not Covered Hospital or Specialist.
7. 5% OFF Discount for 1 Year Plan if pay in cash.
8. 5% OFF Discount if paid in full for 12 months.

SELECT YOUR AGE GROUP
FOR THE SELF-PAY RATE FEE SCHEDULE:

- ☐ AGE 05 – 18 = $30/month
- ☐ AGE 19 – 39 = $50/month
- ☐ AGE 40 – 64 = $70/month
- ☐ AGE 65+ (without Medicare) = $80/month

Automatic Credit Card/Debit Card Payment Authorization Form

I _____ authorize HealthNow Family Practice, LLC to charge my credit card indicated below for amount of _____ on the 1st day of each month for payment of my HealthNow Care Plan.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

□ Discover □ MasterCard □ Visa

_____
Card Number (as shown on card) Exp. Date Security Code

_____
Print Cardholder Name

**Security code is the three-digit number on the back of the credit card or the four-digit number on the front of the American Express Card.*

This authorization form is to remain in full force and effect until HealthNow Family Practice, LLC has received written notification from me of its termination in such manner as to afford HealthNow Family Practice, LLC and card issuer a reasonable opportunity to act on it.

_____ _____

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Signature of Patient or Personal Representative Date

HEALTHNOW CARE PLAN
(FOR UNINSURED AND HIGH DEDUCTIBLE INSURANCE)

Patient's Name	Last:	First:	Middle Initial:
Financially Responsible Party (if different)	Last:	First:	Middle Initial:

If you do not have health insurances or insurances with high deductible and decided to purchase HealthNow Care Plan. You are responsible for the following policies:

1. If you do not have health insurances or insurances with high deductible and now voluntarily decided to buy the "HealthNow Care Plan" at HealthNow Family Practice, LLC.
   _____Please Initial if you Agreed

2. You are responsible for payments of services with monthly charge to credit card or can be paid in full.
   _____Please Initial if you Agreed

3. If you do not paid in full the actual amount or failed to make monthly payment, any subsequent visits are rescheduled until your account balance is cleared. HealthNow have the right to refuse any service if account is not in good standing. If you used up all the allowable visits then you may renew your contract or do self-pay.
   _____Please Initial if you Agreed

4. If you are not able to pay your balance in full for services rendered, please contact our billing department immediately to discuss payment plan options, if any. You cannot continue treatment if an outstanding balance remains on your account prior to the next scheduled appointment.
   _____Please Initial if you Agreed

I, _____("patient/financially responsible party"), agree to the following financial agreement with HealthNow Family Practice, LLC. I agree to pay for services and/or treatment out-of-pocket as outlined in the HealthNow Care Plan Fees Schedule at the time services are provided by HealthNow Family Practice's clinicians. I understand that I am responsible for any and all additional fees services agreed to as described in the "Fee schedule." Furthermore, I understand that failure to make payment as stated in HealthNow Care Plan policy for services rendered that is unpaid for more than 30 days will result in financial penalties, such as, but are not limited to, collection and legal fees. This program is non transferable.

My signature below constitutes acknowledgement and acceptance of this financial agreement between HealthNow Family Practice, LLC and myself.

Responsible Party Signature: _____Date: _____

Patient's Name (printed): _____

Reviewed by (OM/billing only):_____Date:_____

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