Physician Services

6278 N. Federal Hwy Ste 286 Ft. Lauderdale, Florida 33308
Phone 800-208-1009 Fax 954-351-0369

# Remote Access Application Form Program A

I, Dr. _____ agree to these terms of the Remote Access program and only myself or Greg Barnes can modify said agreement in writing.

1. The new program fee is $4.50 per claim._____ Initial.

2. We will remotely access your computer and send all claims electronically from your office that are able to be sent electronically.

3. We will send all paper claims from our office. All Pip and Pi are on a percentage basis.

4. We will post all insurance payments and do write offs from the EOB's provided to us by said client. EOB's will either be scanned and emailed or pulled from the insurance company by Physician Services.

5. We will put all notes from our status calls on your claims in your software.

6. Client will have to have a maintenance contract with their computer software company in force.

7. Client understands that a fee for remote access may be needed and that fee is the responsibility of said client.

8. Client understands that Physician Services will need their own workstation located in the client's office that cannot be shared or used by any other individual except by PS representatives.

9. We charge $35 an hour to do any necessary programming to set up your claims to go electronically or so program will work with us on  a remote basis. _____ Initial.

10. 10. A $300.00 setup fee and $600.00 a month minimum invoice: . _____ Initial.
(This does not pertain to established clients)

11. All invoices are to be paid by due date or before or services will be discontinued. This agreement can be voided with a 30 day written notice. The doctor is personally responsible for all terms of this agreement.

_____
Print client's name

_____
Client's State License Number

_____ _____
Client signature Date

_____ _____
Physician Services Date


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## Invoice Payment Policy

I do hereby understand that my personal insurance CA with Physician Services gets paid upon my payment of invoice. All invoices will be emailed on the 1st of each month and all invoice payments are due in Physician Services office by the due date.

I do understand that if payment is not received then all work on my account will cease until invoice is paid. If payment of invoice is late, a late fee of 10% of invoice amount will be assessed. If my check bounces I agree to pay a $50 bounced check fee. I understand that until I make my check good and pay the S50 bounced check fee all work on my account will cease.

I do understand this invoice payment policy and will comply with the terms.

_____ _____

Doctors signature Date

## Indemnification

Client shall indemnify and defend Company. and its trustees, officers. contractors, employees from and against any actions, suits, claims, judgments, liabilities, costs and expenses (including reasonable attorneys' fees) arising out of or relating to any acts of the Client, especially, but not limited to, client's furnishing Company with any information concerning billing matters. It is clearly understood that the Company makes no investigation of the coding or bills furnished to it by the Client. The Client's obligation to so indemnify and defend the Company shall be for a period of six (6) years following the termination of this Agreement. Nothing in this paragraph or elsewhere in this Agreement shall create or give to third parties any claim or right of action against the Company.

This page must be signed and attached to the agreement form with payment before any billing is started.

_____

Print client's name

_____ _____

Client signature Date

_____ _____

Physician Services Date