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

Percentage Application Form Program C

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

1. This agreement between Dr. _____ is not a contract for any specific period of time and client as well as Physician Services (PS) can terminate the relationship with a 30 day written notice.

2. If client cancels with a 30 day written notice or without they are still responsible for the monthly minimum and or collections of any claims filed by PS, that we verify that have been paid to said client by the insurance company, whichever figure is greater. _____ Initial

3. For any EOB not received by PS after we have found that check has been cashed or received by said client, a $10.00 per EOB fee will be assessed in additional to the %. All EOB's are to be scanned and sent to PS daily or every other day but no longer. Official holidays are excluded. _____ Initial

4. Doctor will provide to PS a 4 to 6 month insurance collections figure, whichever PS asks for. If it is determined that the figures given PS are not valid or not representative of average collections then the percentage can be raised no more than 2% of the original amount. Physician Services can also cancel said agreement. Client will pay the minimum of S600.00 upon cancellation or the percentage of collections whichever is greater. _____ Initial

5. Doctor agrees to pay PS % of all insurance claims filed and paid. Invoices will be sent via fax or email to doctor at the first of every month. _____ Initial

6. Doctor also agrees to pay PS a minimum monthly invoice amount of S600.00, not in addition to the percentage of collections. _____ Initial

7. Doctor also agrees to pay $3.95 for all claims filed for said client whereas the insurance has been maxed, termed or cancelled or goes to deductible. Since client is verifying benefits, it is the client's responsibility to make sure patients insurance is valid and in force. Also for post-service appeals. _____ Initial

8. A setup fee of $300.00 will be paid to PS and a $600.00 a month minimum invoice. PS will prepare all paperwork for the client necessary to file claims electronically as well as any training necessary to remote access and learn doctor's software. _____ Initial

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. Doctor must have active support from their software company that PS can use in case of software problems or any other problems that PS deems necessary to contact software company or in case client cannot assist in solving software problem. _____ Initial

11. Doctor understands that a fee for remote access may be needed and that fee is the responsibility of the doctor. _____ Initial

12. PS will not be paid a percentage of monies collected by front desk staff such as copays or deductibles, excluding all insurance payments. _____ Initial

13. PS will send patient statements at a fee of $2.00 per statement and we will send up to three statements. We do not take a percentage of what is collected on patient statements paid. If doctor wishes, we will send more or less statements but the fee of $2.00 per statement will be paid. _____ Initial

14. Since PS has been contracted to file insurance claims for client all claims sent will be considered sent be PS and percentage of said collections will be paid to PS. Upon agreement with PS. the doctor can send their own PIP claims or other PI, this will be agreed upon by PS and client. _____ Initial

15. If agreement is terminated by either party, the client agrees to give PS 90 days to collect all claims filed by PS and be paid the agreed upon percentage. _____ Initial

16. If is common for deductibles to not have been met when claims are filed on behalf of client. If a filed claims goes to deductible then client will pay PS a fee of $3.95 per claim or the $600 minimum for the month, whichever is greater. _____ Initial

17. Doctor understands that PS will need their own workstation located in the client's office that cannot be shared or used by any other individual expect for PS representatives. _____ Initial

_____

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