



Physician Services

6278 N. Federal Hwy Ste 286 Ft. Lauderdale, Florida 33308

PHONE: 954.495.6845 | WEB: PSMBS.COM | EMAIL: GREGBARNES@PSMBS.COM

# Program B

## Remote Access Application Form

These are Additional Services for new Practitioners

I, Dr. \_\_\_\_\_, doing business as \_\_\_\_\_  PA  PLLC  
Other [specify] \_\_\_\_\_, 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 \$5.25 per claim. \_\_\_\_\_ *Initial.*
2. We will input charges into your software.
3. We will remotely access your computer and send all claims electronically from our office that are able to be sent electronically.
4. We will send all paper claims from our office.
5. We will post all insurance payments and do write off s 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.
6. We will put all notes from our status calls on your claims in your software.
7. Client will have a maintenance contract with their computer software company in force.
8. Client understands that a fee for remote access may be needed and that fee is the responsibility of said client.
9. 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 expect for PS representatives.
10. 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.*
11. A \$450.00 setup fee and \$800.00 a month minimum invoice: . \_\_\_\_\_ *Initial.*  
(This does not pertain to established clients)
12. All invoices are to be paid by due date or before or services will be discontinued.
13. All PIP and PI are on a percentage basis.
14. 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

\_\_\_\_\_  
DOING BUSINESS AS

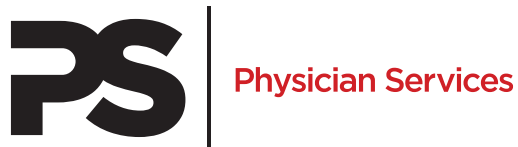
\_\_\_\_\_  
CLIENT'S STATE LICENSE NUMBER

\_\_\_\_\_  
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 \$50 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

\_\_\_\_\_  
DOING BUSINESS AS

\_\_\_\_\_  
CLIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PHYSICIAN SERVICES

\_\_\_\_\_  
DATE



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## Individual Personal Guaranty

IN CONSIDERATION OF STELLER MANAGEMENT INC D/B/A PHYSICIAN SERVICES extending credit to the above listed business, and for other valuable considerations, the undersigned does hereby guarantee payment by the customer to the creditor for all services which has heretofore been and/or hereafter is purchased by the customer and not paid for; and for any other expenses incidental to said transactions, including reasonable attorney fees and collection costs. The guarantor further agrees that, on failure of the customer to pay for such purchases upon maturity of the invoices therefor, said guarantor shall immediately pay the amounts thereof, and the additional charges and expenses enumerated above, together with interest from maturity of each invoice to the date of payment.

\_\_\_\_\_  
PRINT CLIENT'S NAME

\_\_\_\_\_  
DOING BUSINESS AS

\_\_\_\_\_  
GUARANTOR(S)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SS # OR DRIVER'S LICENSE #