

Financial Responsibility

I, _____ the undersigned patient or legal guardian, hereby acknowledge and accept financial responsibility for all charges associated with the medical services provided to me or the patient named above by _____, hereinafter referred to as "the Provider." This agreement outlines the financial responsibilities, billing procedures, and insurance matters related to the medical services.

Insurance Information: I understand that it is my responsibility to provide accurate and up-to-date insurance information to the Provider. This includes the insurance company name, policy number, group number, and any other necessary information. I am aware that insurance coverage varies, and I am responsible for understanding my coverage and any applicable deductibles, co-payments, and out-of-pocket expenses.

Payment Obligation: I understand that I am responsible for all charges incurred for the medical services provided, whether or not they are covered by insurance. This includes, but is not limited to, co-payments, deductibles, non-covered services, and any charges exceeding the limits of my insurance policy. I agree to pay all such charges promptly.

Payment Methods: I agree to make payments for services rendered by the Provider using the following payment methods:

Cash
Check
Credit Card (Visa, MasterCard, American Express, Discover)
Debit Card

Billing Procedures: I acknowledge that I will receive statements from the Provider outlining the services provided and the corresponding charges. It is my responsibility to review these statements for accuracy and promptly notify the Provider of any discrepancies.

Payment Due Date: Payment for all outstanding balances is due within 30 days of receiving a statement. Failure to make timely payments may result in additional charges, including interest and collection fees.

Collection Costs: In the event that my account becomes past due and requires the involvement of a collection agency or legal action, I agree to pay all associated collection costs, including but not limited to attorney's fees and court costs.

Financial Assistance: I understand that the Provider may offer financial assistance or payment plan options for patients facing financial hardship. I will contact the Provider to discuss these options if needed.

Changes in Insurance Coverage: I agree to promptly inform the Provider of any changes in my insurance coverage, including changes in policy, coverage termination, or a change in the primary insurance holder.

Authorization for Release of Information: I authorize the Provider to release any necessary medical information to my insurance company for the purpose of processing claims.

Acknowledgement of Financial Responsibilities

I have read and understand the terms and conditions outlined in this Financial Responsibility Form. I accept full responsibility for payment of all charges associated with the medical services provided by the Provider.

Signature of Patient or Patient's Representative

Date

Printed Name

Representative's Relationship to Patient

