Patients First Healthcare Clinic

FINANCIAL RESPONSIBILITY AGREEMENT (Rev 9/16/11)

Patient Name: _____ Date of Birth: _____

***I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, Preventative exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the Patients First Healthcare Clinic provider or the provider's staff.

***I understand and agree it is my responsibility and not the responsibility of the Provider or Office to know if my insurance will pay for my medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, or any other screening service or diagnostic testing ordered by the Patients First Healthcare Clinic provider or the provider's staff.

***I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

***I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

***I understand and agree it is my responsibility to know if my PCP (primary care Physician/provider) choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

***In order to be respectful of the medical needs of other patients, please be courteous and call Avere Healthcare Clinic at least 24 hours in advance if you are unable to keep your appointment. Failure to do so will result in a fee of $25.00 billed to the patient's account, which must be paid before the next visit.

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE: _____
(If different from patient)

GUARANTOR NAME (Please Print): _____