Financial Responsibility Agreement

Printed Patient Name: _____

Date of Birth: _____ *Visit Date:* _____

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visit. This includes any medical service/visit, preventive/physical exam, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree that it is my responsibility and not the responsibility of the physician or clinic to know if my insurance will pay for my medical service/visit. Preventive/Physical exam, lab testing, x-ray, EKG and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree that 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/plan. If the physician/ provider I am seeing is not contracted with my insurance company/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 that it is my responsibility to know if my PCP choice has been processed by my insurance company/plan. If I have requested a PCP change this is not processed by my insurance company, it may result in claims being denied. I understand this and agree that I am financially responsible and will pay in full.

Responsible Party: _____ *Date:* _____

Signature: _____

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