

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing YOUR OFFICE NAME as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

The patient (or patient's guardian, if minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance. Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered or approved by their insurance plan. Copays are due at the time of service. Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.

PRINT PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

PARENT OR GUARDIAN must sign if patient is under 18 years of age

SIGNATURE: _____ DATE: _____