Statement of Financial Responsibility & Health Plan Coverage

We appreciate your decision to choose our professional services for your health care needs. The health care services that we provide come with a financial responsibility on your part. This responsibility obligates you to pay for our services. As a courtesy, we will attempt to verify your insurance coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of our health care services.

You are responsible for payment of any deductible, co-payment and coinsurance as determined by your contract with your insurance carrier. We collect these payments at the time of service. Many insurance companies have additional requirements or limits that may affect your coverage such prior authorization, visit limits, or other care limits. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you choose to continue treatment beyond the limits of your health plan, you will be completely responsible for payment of this care.

Patient Name: ________________________ Address: ____

Your Primary Insurance coverage information was verified as follows:

Name of Health Plan:	Visit Limit # _________ Per ☐ Month/ ☐ Year Dollar Limit $________ Per ☐ Month/ ☐ Year
Health Plan coverage of charges – type of coverage: ☐ HMO ☐ PPO ☐ Exclusive PPO ☐ Out of Network	_____________ % Health Plan Coverage _____________ % Patient Responsibility
Deductible per year:	$ _______ of which $ _______ has been met
Out-of-pocket limit per year:	$ _______ of which $ _______ has been met
Co-Pay:	$________ Each visit
Prior Authorization or Referral necessary: ☐ Yes ☐ No	Obtained: ☐ Yes ☐ No Who Approved:
Verification: Health Plan Contact Person:	Phone # Date & Time:

Your Secondary Health Plan coverage information was verified as:

Name of Health Carrier ________________________________ Policy# __________________________

I have read this agreement regarding my financial responsibility for health care services provided to me or for the patient for whom I am financially responsible. I certify that the information I have provided is true and accurate to the best of my knowledge. I authorize my insurer or other benefit plan to pay you directly for the services delivered. I agree to pay the full amount of all charges for care delivered to me or to the patient for whom I am financially responsible that remain after payment has been made by my insurer or other benefit plan.

Signature: ____ Date: _______________________

Relationship to patient: ☐ Self ☐ Parent ☐ Guardian ☐ Other ____________________________

PATIENT ATTENDANCE POLICY

We allocate a specific time for your appointment to meet your needs. We understand that there may be times when you must miss an appointment, but if you fail to provide us with 24-hour advance notice of cancellation, you will be charged $ ______________ for the missed appointment which will not be paid by your health plan.

Signature: ____ Date: _______________________

Relationship to patient: ☐ Self ☐ Parent ☐ Guardian ☐ Other ____________________________

© 2011