



Patient Name: _____ Date of Birth: ____/____/____

Statement of Patient Financial Responsibility

America's Family Doctors, PLLC appreciates the confidence you have shown in choosing us to provide for your health care needs. The services you have elected to participate in, implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier/s on your behalf. However, you are ultimately responsible for payment in full of your bill.

Many insurance companies have additional stipulations that may affect your coverage. **It is ultimately the patient's responsibility to know your coverage and benefits.** I authorize AFD to furnish information to insurance carriers concerning my care. You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your balance in full. **It is the patient's responsibility to obtain referrals or authorizations required by the insurance carrier to be seen at AFD Clinics.**

If any tests are performed by the lab you may receive a separate bill from their offices that you are financially responsible for. Full payment for AFD services provided is due at the time of services rendered; fees and Interest may be charged.

If payment is denied for lack of authorization, I understand that I am responsible for payment in full.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Some health insurance carriers require the patient to pay a co-pay for services rendered. This is a contract between you and your insurance carrier. Payment of all co-pays is expected at the time the service is rendered for the patients.

I understand that I am responsible for co-payments and deductible/co-insurance as dictated by my insurance carrier.

Initial _____

I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees and any other charges incurred in the collection of any balance due. I further understand that a fee of, as much as **35%**, will be added to my total account balance in accordance with this facility's contract with its collection agency.

Initial _____

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, you must call the office prior to your appointment time to cancel or reschedule your appointment.

I understand if I miss an appointment without canceling in advance I will be charged a \$25 no-show fee and I will not be allowed to schedule another appointment until that fee is paid in full.

Initial _____

I have read the above policy regarding my financial responsibility to AFD, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to AFD. I understand that any amount remaining after such payment has been made by my insurance carrier becomes the patient's responsibility.

(Signature of patient OR parent/guardian if under the age of 18)

(Date)

(Print Name)