Financial Responsibility

Important Information Regarding Your Account

Statement of Financial Responsibility

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred.

Notice of "Non-Covered" Services

I am aware that some services performed by the Practice may be considered "non-covered" by my insurance carrier or Medicare, therefore I will become fully responsible for payment of these services.

Waiver of "Usual, Customary and Reasonable" Clauses *(For patients with "Out-of-Network" coverage)*

I acknowledge that the fee charged by the Practice for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary and reasonable," due to specialized services and staff. However, I agree to pay the Practice fees in full, even if the amount is greater than what I am reimbursed from my insurance company.

Bill To/Payment Instructions

_____ Commercial Insurance/Third Party Payor _____ Medicare _____ *Medigap
Initial Initial Initial

I hereby authorize the Practice to bill my insurance company and/or Medicare (indicated or initialed above) for services provided to me and request that payments for such services to be made to the Practice on my behalf.

***If Medigap**_____ _____ _____
Name of Beneficiary Medigap Policy Number Health Insurance Claim Number

List Names of Those with Whom You Want Us to Share Your Financial Responsibility Information:

Name: Relationship:

_____ _____

_____ _____

_____ _____

Financial Agreement

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an outside agency or an attorney for collections, the undersigned agrees to pay reasonable collection and attorney fees for collection expenses.

Patient's name: _____
(please print)

Patient (or legal guardian's) signature: _____

Date: _____

If legal guardian, relationship to the patient: _____

BayCare Medical Group