PATIENT FINANCIAL RESPONSIBILITY FORM

Patient Name: _____ Date of Service: _____

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

I understand the following:

- I am financially responsible for my cost-sharing obligation, as further detailed below.
- Co-payments are due at the time of service.
- If my health insurance plan requires a referral, I must obtain such a referral prior to my visit.
- In the event that my health insurance plan determines a service to be non-covered or "not payable," I will be responsible for the entire charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

**Practice will designate the applicable category, which must be signed and dated by the patient.*

☐ I understand that Practice is in-network with my health insurance plan and I am receiving **non-COVID-related** healthcare items and services. As such, I will be financially responsible for my cost-sharing portion associated with the services I receive, including, but not limited to deductible amounts, copayments, or payment for services deemed not covered by my health insurance plan.

Patient Initials: _____

☐ I understand that Practice is in-network with my health insurance plan and I am receiving **COVID-related** healthcare items and services. Pursuant to the Family First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act), my health insurance plan is responsible for covering 100% of these items and services and I should not be responsible for any cost-sharing obligation. However, in the event my healthcare insurance plan does not cover all or any portion of these services, I will be financially responsible for any outstanding amounts.

Patient Initials: _____

☐ I understand that Practice is out-of-network with my health insurance plan and I am receiving **non-COVID-related** healthcare items and services. As such, I understand that I will be financially responsible for my cost-sharing portion associated with the services I receive, including, but not

limited to deductible amounts, copayments, or payment for services deemed not covered by my health insurance plan.

Patient Initials: _____

☐ I understand that Practice is out-of-network with my health insurance plan and I am receiving **COVID-related** healthcare items and services. Pursuant to the FFCRA and the CARES Act, my health insurance plan is responsible for covering 100% of these items and services and I should not be responsible for any cost-sharing obligation. In the event my health insurance plan determines I am responsible for any cost-sharing obligation, Practice will only charge me an amount equal to the cost-sharing obligation if Practice was in-network with my health insurance carrier. In the event my healthcare insurance carrier deems the services non-covered or not payable, I will be responsible for the cost of such services.

Patient Initials: _____

☐ I am uninsured and will be responsible for full payment of the medical services rendered to me at the time of service.

Patient Initials: _____

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize assignment of financial benefits directly to Practice and its associated healthcare entities for services furnished to me by the Practice. I understand that I am financially responsible for charges not covered by this assignment.

AUTHORIZATION TO RELEASE RECORDS

I authorize the Practice to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for pre-certification, authorization, or referral to other medical provider.

ACKNOWLEDGMENT

I have read and understand this Financial Responsibility Form described above. I agree to pay promptly and in full the amounts due to the Practice for all items and services.

Signature: _____ Date: _____
Patient, Authorized Representative or Responsible Party

Print Name: _____ Relationship to Patient: _____
Patient, Authorized Representative or Responsible Party