

**Practice
Logo**

Practice Name
Street Address
City, State Zipcode

FINANCIAL ARRANGEMENTS

In connection with rendering health care services by [Practice Name], the patient and/or the responsible party for the patient is required to indicate which method of payment is applicable to the patient. The patient is also responsible for any deductible and/or out of pocket expense determined by the individual insurance plan. Method of payment accepted is **cash, check, money order, VISA, MasterCard, Discover and American Express**. The fee for returned checks is \$25.00 and will be charged to your account. By signing below, you acknowledge that any agreement in regards to your insurance plan is an agreement between the you, the policy holder and the carrier and that any claims filed by [Practice Name] is only done as a courtesy to our patients.

INSURANCE PLAN

I have commercial insurance and have assigned benefits to authorize payment to [Practice Name] in accordance with the assignment of Health Insurance Benefits I have executed on this date. Any payment made to me will be forwarded to [Practice Name] upon receipt. I will pay all applicable charges not paid by the insurance as billed by [Practice Name].

_____(Initials)

SELF-FUNDED (ERISA)

I understand that my insurance plan is self-funded which means that it is excluded from all state laws for prompt and/or correct payment. Should my insurance carrier choose not to process my claims to pay benefits appropriately, I understand that the **charges can and will be put to my responsibility for payment and it will be my responsibility** to contact the United States Department of Labor at (866) 275-7922 to make complaints of non-payment by my insurance carrier.

_____(Initials)

WORKER'S COMPENSATION

A claim for Workers' Compensation benefits has been filed by my employer and approved by his/her insurance carrier. In the event Workers' Compensation denies my claim, I will assume financial responsibility for all medication, supplies, equipment and clinical services as rendered and invoiced by [Practice Name]. _____(initial)

MEDICARE

I have Medicare coverage and have authorized payment to [Practice Name] in accordance with the Assignment of benefits that I have executed on this date. **I also understand that Medicare does not cover prescription drugs, therefore, will not pay for outpatient IV antibiotics outside the physician's office or hospital.** Per Medicare guidelines, if the service or supply is statutorily excluded, when filed to Medicare, it will result in an automatic denial, making it the patient responsibility. If there is a secondary insurance, [Practice Name] will file that claim. _____(initial)

UNINSURED

I have no insurance and will pay [Practice Name] 25% of the estimated cost of therapy prior to the start of therapy. I will pay the remaining balance in 3 equal monthly installments. I am aware that the therapy could change, therefore changing the final billed amount by [Practice Name]. _____(initial)

In consideration of and to induce [Practice Name] to retain _____ as a private patient, the undersigned, _____ assumes full responsibility for and agrees to pay all costs, charges and expenses of _____(patient) of every kind and description of services, facilities, medication and any other items supplied and/or furnished to the patient. This is an original undertaking on the part of the undersigned, and obligations of the undersigned hereunder are the direct and primary obligations of the undersigned. No extensions, indulgences or forbearance's which may be granted to the patient and no delays or lack of diligence in enforcing any rights against the patient shall in any manner release the undersigned of affect the undersigned's liability hereunder. If the undersigned is more than one person, every obligation(s) hereunder shall be joint and several. The obligations of the undersigned hereunder shall be cumulative with and in addition to all other remedies against the patient.

Dater Insurance Verified: _____ Insurance Calander Year/Plan Year: _____
Deductible \$ _____ Met \$ _____ coverage once met _____ % OOP \$ _____ Met \$ _____ Lifetime Max \$ _____
Physician Office Co-Pay \$ _____ Estimated Patient Responsibility _____
Past Due Balance? _____

I would / would not like a copy of this form. _____ (Please circle and initial)

Patient or Responsible Party Signature Date Witness Signature Date

Patient Name (Please Print) Patient Date of Birth Patient Social Security Number

Implemented on: 1/1995	Revised Date: 03/2006
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