Patient: _____
(Please print)

Date of Service: _____

Patient Statement of Financial Responsibility

- I understand and agree that my co-payment, co-insurance and deductibles are due and payable at the time of service, and I may receive a bill for any amounts due that are not collected at time of service.

- I understand that services not covered through my benefits, as well as any applicable co-payments and deductibles are my responsibility.

- I understand that an inactive insurance card, no insurance, no insurance card, or insurance we are not a participating provider for will render me responsible for payment for services.

The Insured/Guardian/Patient is advised that a copy of the patient's insurance card is required to submit a claim.

The Insured/Guardian/Patient is advised that this document will become a part of the patient's medical record and billing statements will be sent for services should any of the above occur.

The Insured/Guardian/Patient is also advised that most carriers have a claims filing limit. Correct insurance information received greater than 60 days from the date of this document may be denied by their carrier as untimely and the insured/guardian/patient will be held responsible for any balance.

Guardian/Insured/Patient: _____
(Signature)

Date: _____

Staff Initials: _____