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FINANCIAL RESPONSIBILTY

Patient Name: ______________________________

Date of Birth: ____________________ Today's Date: ____________________

1	I understand that it is my responsibility to be knowledgeable about the scope of coverage that my insurance provides. I acknowledge it is NOT the responsibility of the doctor to interpret my benefits and assume responsibility for coverage. I understand my benefits for laboratory services order by the doctor and I understand that many of the services provided to patient are not considered medically necessary under their definition of this term, and I accept MY responsibility for all services provided by my doctor to me in this regard. I also understand that by allowing my blood drawn, I authorize the doctor to perform the recommended tests and I agree to assume all financial responsibility for these tests.
2	I understand that my insurance company may have a co-payment or deductible component of the bill and hereby agree to pay my doctor for that portion which I am deemed responsible.
3	I understand that, as a courtesy to the patients, the doctor may bill my insurance provider in those cases for which a relationship has been established between the insurer and my doctor. For instance, in case of HMO managed care services, the doctor will collect a co-pay and any deductible fees and bill the insurer for services which it feels is covered as a benefit.
4	I understand that if the insurer denies payment for any reason, I will be full responsible for all outstanding charges. All benefit given to the patients are a quotation not a guarantee of payment.
5	I understand that if I request medical records, I will be charged a fee for photocopies. I understand that I will be charged a $25.00 fee if I need any FMLA/Disability forms filled out by the doctor.
6	I understand that I will be charged a $35.00 for any returned check.
7	I agree to pay all legal and other expenses that the doctor may incur as a result of actions taken to collect unpaid balances for which I am responsible.
8	I consent the doctor and the staff to communicate with me via e-mail regarding the following aspects of my medical care and treatment: prescriptions, appointment, billing, etc. I understand that e-mail is not a confidential method of communication. I further understand that there is risk that e-mail communications between my physician and me or staff members regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties.
9	I also understand that any e-mail communications between my physician and me or staff members regarding my medical care or treatment will be scanned and made part of medical records. I understand that in an urgent or emergent situation, I should call my provider or go to the emergency room at the nearest hospital and not rely on e-mail.

I, ______________________________ , have read and agree to the above thereby accepting financial responsibility for those services the office and my doctor provide to me.

Signature: ______________________________