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Patient Financial Responsibility Form

Patient acknowledgment of financial obligations — obtain signature before or at time of service

[Practice Name]
[Address, City, State, ZIP]
[Phone] | [Fax]

Date: ______________________
Chart #: ______________________

PATIENT INFORMATION

Patient Name:	*[Last, First, MI]*
Date of Birth:	*[MM/DD/YYYY]*
Address:	*[Street, City, State, ZIP]*
Phone:	*[Phone Number]*
Email:	*[Email Address]*
SSN (last 4):	*[####]*
Employer:	*[Employer Name]*
Emergency Contact:	*[Name / Phone]*

INSURANCE INFORMATION

Primary Insurance:	*[Insurance Company]*
Policy / Member ID:	*[ID Number]*
Group Number:	*[Group Number]*
Policy Holder:	*[Name if not patient]*
Policy Holder DOB:	*[MM/DD/YYYY]*
Relationship to Patient:	*[Self / Spouse / Child / Other]*

Secondary Insurance:	*[Insurance Company or N/A]*
Policy / Member ID:	*[ID Number]*
Group Number:	*[Group Number]*
Policy Holder:	*[Name if not patient]*

FINANCIAL POLICY & PATIENT AGREEMENT

COPAYS & COST-SHARING

Copayments, coinsurance, and deductible amounts are due at the time of service. We accept [cash / check / credit card / HSA-FSA]. Our office does not waive copays or deductibles — doing so would constitute a violation of your insurance contract.

INSURANCE BILLING

As a courtesy, we will bill your insurance company on your behalf. However, you are ultimately responsible for payment of all charges, regardless of insurance coverage. If your insurance denies or reduces payment for any reason, you are responsible for the remaining balance.

NON-COVERED SERVICES

Services not covered by your insurance plan, or services rendered to uninsured patients, are due in full at the time of service unless a payment arrangement has been made in advance. We will make reasonable efforts to verify your benefits, but coverage verification is not a guarantee of payment.

PAST-DUE BALANCES & COLLECTIONS

Balances not paid within [30/60/90] days of your statement date may be subject to a late fee of [$ / %] per month. Accounts past due by more than [90/120] days may be referred to a collection agency. You are responsible for all collection costs, including reasonable attorney's fees. A returned check fee of $[amount] will be assessed for all returned checks.

ASSIGNMENT OF BENEFITS

By signing below, you authorize [Practice Name] to: (1) release any medical information necessary to process your insurance claims; (2) assign insurance benefits directly to [Practice Name]; and (3) submit claims to your insurance carrier on your behalf.

PATIENT / GUARDIAN ACKNOWLEDGMENT & SIGNATURE

I have read and understand the Financial Policy of [Practice Name]. I agree to be responsible for all charges incurred for services rendered, including amounts not covered by my insurance. I authorize the release of medical information as necessary for billing purposes and assign insurance benefits directly to this practice.

Patient / Guardian Signature:	______________________________
Printed Name:	*[Printed Name]*
Relationship to Patient:	*[ ] Self [ ] Parent [ ] Legal Guardian [ ] Other:* ______________
Date:	*[MM/DD/YYYY]*

Staff Witness: ______________________________

OFFICE USE ONLY — Copy provided to patient: [ ] Yes Copy filed to chart: [ ] Yes

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