Patient Financial Responsibility and Billing Agreement

Please read carefully, complete the required fields, and sign below. This agreement must be completed prior to receiving services.

1. Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Insurance Provider:

Policy Number / Member ID:

2. Financial Agreement & Policies

Insurance Billing: We will bill your insurance company as a courtesy. However, you are ultimately responsible for the payment of all services rendered. It is your responsibility to provide accurate and up-to-date insurance information.

Co-payments, Co-insurance, and Deductibles: All co-payments, co-insurance, and outstanding deductibles are due at the time of service. We accept cash, personal checks, and major credit cards.

Non-Covered Services: Please be aware that some services may not be covered by your insurance plan. You agree to pay for any services that your insurance company determines to be "non-covered" or "not medically necessary."

Late Cancellations and No-Shows: We require a 24-hour notice for cancellations. Failure to provide adequate notice or failure to show up for your appointment may result in a cancellation fee, which is not billable to insurance.

3. Acknowledgment & Authorization

By signing below, I acknowledge that I have read, understand, and agree to the terms of this Patient Financial Responsibility and Billing Agreement. I authorize the release of any medical information necessary to process insurance claims and authorize payment of medical benefits directly to the provider.

Name of Responsible Party (if different from patient):

Relationship to Patient:

Signature of Patient or Responsible Party (Type Name):

Date (MM/DD/YYYY):