# PATIENT FINANCIAL RESPONSIBILITY FORM

***Patient Financial Responsibilities***

- The patient (or patient's guardian, if a minor) is responsible for the payment for her treatment and care. We are pleased to assist you by billing our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges if the information provided is not correct or updated. If you have any change in your insurance coverage – even a small change, you must notify office staff to avoid claim denial
- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Deductible details are determined by the contract you have with your insurance carrier. Office staff does not know how much each patient's deductible amount is or how much has been met at the time of your visit.
- Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.
- Preventive care visits are an important part of total care. If labs/tests are performed due to complaints mentioned at the time of the visit, additional costs may be incurred that may not be covered by insurance.
- Patients may incur, and are responsible for the payment of additional charges at the discretion of HER Wellness Health Center. These charges may include (but are not limited to):

    Charge for returned checks ($35)
    Charge for missed appointments without 24 hours advance notice ($50)
    Charge for the copying and distribution of patient medical records (0.65c per page)
    All costs associated with collection of patient balance

***Patient Authorizations***

- By my signature below, I hereby authorize HER Wellness Health Center, the physician, and staff to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care.
- This information may include:
    Diagnosis, evaluation, and/or treatment for alcohol and/or drug abuse.
    Records of HTLV-III or HIV testing (AIDS test) result, diagnosis, and/or treatment.
    Psychiatric and/or psychological records, or evaluation and/or treatment for mental, physical, and/or emotional illness, including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluations
- By my signature below, I hereby authorize assignment of financial benefits directly to HER Wellness Health Center and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize HER Wellness Health Center personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information

**I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:**

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Signature of Patient or Guardian | Date