Senior Care
MEDICAL ASSOCIATES, INC.

PATIENT FINANCIAL RESPONSIBILITY

As a courtesy to our patients, we are enrolled in many insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly.

- It is your responsibility to understand your insurance plan(e.g. lapse in coverage, preferred provider, and network restrictions).
- You are required to provide us with the most correct and updated information about your insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
- You are responsible for the payments of co-payments, co-insurance, deductibles and all other procedures or treatment not covered by your insurance plan. Co-payments are due at the time of service.
- If your insurance has not paid the claim within 60 days from the date insurance was billed, you will be responsible for payment. Failure to pay your account or make suitable financial arrangements may result in your account being placed in a state of delinquency.
- Any returned check will result in a fee of $25.00.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

A copy of this agreement may be used in place of the original.

X _____ _____

Patient signature *or legal/personal representative* Date

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Patient name(PRINT)

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Legal/personal representative name(PRINT), *if applicable*