Patient Financial Responsibility

Please read and sign where indicated. This document describes your financial responsibilities.

__I agree to be financially responsible for payment of Fairlawn Family Practice services. Check, credit cards, MasterCard, Discover and Visa are acceptable forms of payment for these services. **We accept no cash.**

__Current insurance cards must be presented at every office visit. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.

__I understand if my account becomes over 30 days past due there may be a Statement Fee added each month of $10.00 to cover the costs of billing.

__I agree to give Fairlawn Family Practice my complete and accurate insurance information for primary and secondary insurance benefits. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment at which time balance is due in full.

__I understand there will be a $35.00 fee for all returned checks.

__If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

__Fairlawn Family Practice may or may not have a contract with your insurance company. Fairlawn Family Practice will receive payments from my insurance company for covered services provided by my insurance benefits. I agree to pay co-payments and deductible at the time of service. If co-payments are not made at the time of service, I understand that my appointment may be rescheduled.

__I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give Fairlawn Family Practice my current address and other contact information. I understand that if I fail to pay the balance on my account this may result in Fairlawn Family Practice pursuing any collection means possible along with discharge from the practice.

__If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees and collection agency costs.

__If the reason for my appointment is related to a work injury, I agree to give Fairlawn Family Practice the claim number, the workman's compensation or insurance carrier name, address or other contact information at the time of my appointment. If I do not provide this information at the time of the visit, I agree to pay all charges for my visit.

I have read and I understand Fairlawn Family Practice's financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient Signature **Date**

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to Fairlawn Family Practice. This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document.

I authorize the release of any medical information necessary in order to obtain payment and I understand that I am financially responsible for all charges, late fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured I am responsible for the charges of all services provided to me.

I HAVE READ AND I UNDERSTAND FAIRLAWN FAMILY PRACTICE'S FINANCIAL POLICIES AND I ACCEPT RESPONSIBILITY FOR THE PAYMENT OF ANYT FEES ASSOCIATED WITH MY CARE.

_____ _____

Patient Signature **Date**