FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: ___________________________ **DOB:** __________________

I understand and agree that I will be financially responsible for any and all charges for services rendered or not paid by my insurance. This includes any medical service(s), preventative exam/physical, lab or diagnostic testing, and any other screening service ordered by the physician or the physician's staff.

I understand and agree that it is my responsibility and not the responsibility of the physician or staff to know if my insurance will pay for such medical service(s), preventative exam/physical, lab or diagnostic testing, or any other screening service ordered by the physician or the physician's staff.

I understand and agree that it is my responsibility to know if my insurance has any Deductible, Co-Payment, Co-Insurance, Out-of-Network, Usual and Customary Limit or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if the provider that I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the provider I am seeing is not, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make payment in full.

I understand and agree that it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make payment in full.

I hereby authorize payment of medical benefits directly to **Pediatric Partners of Stafford** for services rendered. Authorization is hereby granted to release information contained in my medical record to my insurance company or its employees/agents as may be necessary to process and complete my medical insurance claim(s). I understand that I am financially responsible for all amounts payable with regards to fees for healthcare services rendered now or in the future by this practice. In the event of non-payment by me of any amount due to this practice after 90 days, I agree that in addition to the original amount due, I am fully responsible to pay collection fees of 33% and 1/3 of the amount due, court costs, and reasonable attorney's fees incurred by this practice. The duration of this authorization is indefinite and continues until revoked in writing.

Responsible Party

Signature: ___________________________ **Date:** ____________________

Print Responsible Party Name________________________