

FINANCIAL RESPONSIBILITY AGREEMENT



Patient Name: _____ DOB (Date of Birth): _____

Please read and initial the following disclosures and consents to ensure you understand and agree to them:

REQUIREMENT TO DISCLOSE COMPLETE AND ACCURATE INSURANCE INFORMATION:

I understand that my state-issued identification, and current insurance card(s) may be requested at each appointment. I also understand I am required and am responsible to disclose all health insurance coverage I currently hold, including primary, secondary, and subsequent insurance plans, at the time of registration and at every visit. This includes commercial insurance, Medicare, Medicaid, and any other government-sponsored or private health plan. I agree to notify the practice immediately of any changes to my coverage, including the addition, cancellation, or replacement of any plan.

I understand that failure to disclose insurance coverage completely and accurately, including secondary or tertiary/ subsequent plans, at the time of service may result in (1) my personal financial responsibility for balances that may have otherwise been covered, and (2) a review of my continued care relationship with this practice.

_____ (Patient's Initials)

INSURANCE INFORMATION (Please fill out SECTIONS 4-6 even if you are providing your insurance card(s)):

PRIMARY INSURANCE	1. Insurance Company:	2. Policy ID Number:	3. Group ID Number:
	4. Policy Holder's Name: <input type="checkbox"/> Self (if self, skip 5-6)	5. Relationship to Patient:	6. Policy Holder's DOB:
SECONDARY INSURANCE	1. Insurance Company:	2. Policy ID Number:	3. Group ID Number:
	4. Policy Holder's Name: <input type="checkbox"/> Self (if self, skip 5-6)	5. Relationship to Patient:	6. Policy Holder's DOB:
SUBSEQUENT INSURANCES	1. Insurance Company(s):	2. Policy ID Number(s):	3. Group ID Number(s):
	4. Policy Holder's Name: <input type="checkbox"/> Self (if self, skip 5-6)	5. Relationship(s) to Patient:	6. Policy Holder's DOB(s):

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION:

I acknowledge that my insurance plan is a contract between myself and my insurance company. I understand that while this practice may provide an estimate of what my insurance carrier may pay, the final determination of my eligibility and benefits is made solely by my insurance company. I hereby elect to have this office bill my insurance carrier as a courtesy, and authorize direct payment of my insurance benefits to Samuel Landero MD PA (doing business as Arroyo Vista Family Medicine) for services rendered to my dependents or me by the physician or the designees under his/her supervision. I also authorize the release of my dependent's or my medical or incidental non-public personal information that may be necessary for the processing of insurance benefits.

_____ (Patient's Initials)

VERIFICATION OF INSURANCE COVERAGE (INCLUDING COORDINATION OF BENEFITS) AND FINANCIAL RESPONSIBILITY:

I understand it is solely my responsibility, not the responsibility of this practice, to verify my insurance coverage, benefits, coordination of benefits, network status, and any applicable deductible, co-payment, co-insurance, out-of-network costs, or other benefit limitations prior to receiving services. This includes confirming coverage for all services ordered by the physician or staff. I understand that I am fully responsible for any charges not paid by my insurance, including amounts denied, applied to my deductible, deemed non-covered, or processed as out-of-network. I agree to pay all such amounts when due, and I understand that any questions, disputes, or appeals regarding insurance determinations must be directed to my insurance company and do not delay or eliminate my financial responsibility to this practice.

_____ (Patient's Initials)

LABS/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, or other diagnostic services. I understand that I am financially responsible for any balance due for these services if they are not covered by my insurance for whatever reason.

_____ (Patient's Initials)

TELEHEALTH / VIRTUAL VISIT BILLING:

I understand that telehealth/virtual visits are billed as medical services and are subject to the same financial policies as in-person visits. I acknowledge that telehealth coverage varies by insurance plan and it is my responsibility to verify my coverage prior to my visit. I understand that any balance not covered by my insurance remains my personal financial responsibility.

_____ (Patient's Initials)

PATIENT'S ROLE IN VERIFYING REFERRALS AND AUTHORIZATIONS PRIOR TO SEEING SPECIALISTS:

When seeing a specialist or being referred out, I understand that it is my responsibility to ensure that all referrals and prior authorizations required by my insurance plan are current, valid, and confirmed with the receiving provider, specialist, or facility before services are rendered. I acknowledge that while this office will make reasonable efforts to assist in coordinating referrals and authorizations, I am ultimately responsible for confirming with the receiving provider that all items required by my insurance plan are in place to avoid non-covered services. I further understand that prior authorization requests require adequate processing time, and I agree to abide by the practice's Referral Policy by submitting requests with sufficient advance notice. I acknowledge that last-minute authorization renewals or requests are likely to result in delayed or non-covered services.

_____ (Patient's Initials)

GOOD FAITH COST ESTIMATE (PRIVATE-PAY PATIENTS):

In accordance with the federal No Surprises Act, patients who are uninsured or elect not to use insurance have the right to receive a Good Faith Estimate of expected charges for scheduled services, upon request, prior to services being rendered. I understand that estimates are based on information known at the time and that actual charges may vary if additional services are required. I acknowledge that I am responsible for payment of all services provided.

_____ (Patient's Initials)

PAYMENT AT THE TIME OF SERVICE AND OUTSTANDING BALANCES POLICY:

I understand that co-pays, deductibles, coinsurance, are due at the time of service and that this practice cannot waive deductibles, coinsurances, or copays that are required by my insurance as this is a violation of insurance rules. I further understand that any balances not covered by my insurance are due upon receipt of a statement.

I acknowledge that this practice reserves the right to reschedule or decline non-emergent services until my account is brought current. I understand that payment plan arrangements may be requested and are subject to office approval. I further acknowledge that outstanding balances may be referred to a third-party collection agency, and that unresolved balances may result in dismissal from this practice with written notice.

_____ (Patient's Initials)

AGREEMENT TO NO-SHOW / LATE CANCELLATION POLICY:

I understand and agree that failure to appear for a scheduled appointment, or failure to cancel within the time frame required by clinic policy, may result in a no-show or late cancellation fee. I understand no-show fees are not covered by my insurance company and I will be responsible for payment in full.

_____ (Patient's Initials)

By signing below, I certify that I have read and understood the above information and any questions I had were answered. My signature also certifies my agreement with the above policies. A photocopy of this document is as valid as the original.

Signature of Patient, Parent, or Legal Guardian

Date

Witness (Staff) Signature

Date