CLINIC: _____ *THOC, P. A.* _____ Date of Visit: _____

FINANCIAL RESPONSIBILIITY AGREEMENT

Patient Name: _____ Date: _____

I understand and agree that I will be financially responsible for any and all medical charges for service not paid by my insurance for my visits. This includes Medical services or visit, Preventative exam or physical, Lab testing, X-ray, EKG, and any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility an not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, and any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductable, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the service I receive, and I agree to make full payment.

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

I understand and agree it is my responsibility to know if my PCP choice has been processed by 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 full payment.

Signature: _____ Date: _____
(Please sign here-----Patient or Responsible Party)

Responsible Party Name: _____
(Please print name of Responsible Party if different from Patient)