SPRINGFIELD FAMILY MEDICAL CENTER

123 Medical Plaza Drive • Springfield, IL 62701 • Phone: (555) 123-CARE

FINANCIAL RESPONSIBILITY AGREEMENT

IMPORTANT: Please read this agreement carefully. By signing below, you are agreeing to the financial policies and payment terms outlined in this document.

PATIENT INFORMATION

Financially Responsible Party

Relationship to Patient

INSURANCE AND PAYMENT POLICIES

1. INSURANCE VERIFICATION AND COVERAGE

I understand that Springfield Family Medical Center will verify my insurance coverage as a courtesy, but I am ultimately responsible for knowing my insurance benefits, limitations, and requirements. I acknowledge that:

- Insurance coverage is not a guarantee of payment
- I am responsible for obtaining any required referrals or pre-authorizations
- Some services may not be covered by my insurance plan
- I am responsible for any deductibles, co-payments, and co-insurance amounts

☐ **I understand and agree to the insurance policies stated above**

2. PAYMENT TERMS

Payment is due at the time services are rendered unless prior arrangements have been made. I agree that:

- Co-payments and deductibles are due at the time of service
- Payment is expected within 30 days of receiving a statement
- A service charge of 1.5% per month may be applied to accounts over 60 days past due
- I am responsible for all collection costs, including reasonable attorney fees, if my account is referred for collection

☐ **I understand and agree to the payment terms stated above**

3. APPOINTMENT AND CANCELLATION POLICY

I understand that my appointment time is reserved specifically for me. I agree that:

- I will provide at least 24 hours notice if I need to cancel or reschedule
- A $50 fee may be charged for missed appointments or cancellations with less than 24 hours notice
- Repeated no-shows may result in dismissal from the practice

☐ **I understand and agree to the appointment policies stated above**

FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

I acknowledge and agree that:

1. I am financially responsible for all charges incurred for medical services provided to me or my dependents
2. I will pay all co-payments, deductibles, and non-covered services at the time of service
3. If my insurance company requires a referral or pre-authorization, it is my responsibility to obtain it
4. I will notify the office immediately of any changes to my insurance coverage or contact information
5. I assign my insurance benefits to Springfield Family Medical Center for services rendered
6. I authorize the release of any medical information necessary to process insurance claims
7. Any insurance payments made directly to me will be forwarded to Springfield Family Medical Center immediately
8. I understand that some insurance plans require the use of specific laboratories or facilities, and I am responsible for using in-network providers when required

PAYMENT METHOD PREFERENCES

Preferred payment method:

☐ **Cash** ☐ **Check** ☐ **Credit Card** ☐ **Auto-pay**

By signing below, I acknowledge that I have read, understood, and agree to all terms of this Financial Responsibility Agreement. I certify that the information provided is accurate and complete.

Patient/Responsible Party Signature

Date

Print Name

For Office Use Only:

Staff Signature

Date