Financial Responsibility Form

Date: _____

Patient Name: _____

Practice Name: Aronson & Rosenthal, M.D., Inc.

As positive verification of my medical coverage cannot be made at this time, I agree to pay for any and all medical services I receive from the doctors and ancillary providers (laboratory fees, etc.) of this practice should my insurance company refuse to pay for my care.

Should my insurance carrier refuse payment (e.g., non-covered services, no benefits for preventive medicine visits, my failure to secure a referral from my primary care physician, the doctor is not a panel member of my medical group / IPA, etc.), I will pay for all services rendered upon receiving a written and/or verbal notice of the denial of my claim. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visit(s) with the diagnosis that was encountered and documented in my medical record. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

In the event I do not pay for these or any other services provided to me when due, I agree to pay all costs associated with collection, including reasonable attorney fees (whether or not a law suit is commenced) as part of the collection process.

By my signature, I certify to having read the above statements and fully understanding my financial responsibility for ***all care rendered to me so long as I am a patient of this practice*** regardless of any changes in my insurance coverage.

_____

Patient Signature (or responsible party if minor)

_____

Witness