PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Wellstar Physicians Group

Marietta Internal Medicine 54 Tower Road, Marietta, GA 770-427-4682

Patient Name_________________________________**Date of Birth**_____________________

In consideration of the services provided at the Practice identified above:

- *If you provided us with insurance information, you are obligated to pay all co-payments, deductibles and any non-covered out-of-network/reduced benefits at the time services are rendered. You will subsequently be invoiced for any additional amounts which are not paid by your Insurer. You have an affirmative duty to make sure that payment and/or correct information for payment is given to the Practice for reimbursement of services provided*

- **I, the undersigned, hereby assign** all hospital and medical provider benefits payable (i.e. "Payor" Insurance Coverage, Medicare, Medicaid, Social Security, etc.) and related rights existing under the Payor coverage that I have identified or will identify in connection with the services provided directly to the Practice and acknowledge this includes my permission to submit all my patient health information, including privileged information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes. This assignment will remain in effect until revoked by me in writing.

- **I understand** if the Practice elects to pursue an appeal of any denials by my Payor of the payment for services rendered, this Statement constitutes written consent that Practice and/or its agents have the authority to pursue any and all appeals, including arbitration, on my behalf. This financial responsibility is hereby affirmed and acknowledged by my signature below.

- **I understand** that any payment received by the Practice for this period may be applied to any unpaid bill(s) for which I am liable.

- **I understand** that different insurances have different requirements for payment including, but not limited to, pre-certifications, referrals, authorizations or that the services be medically necessary.

  - **I understand** that it is my obligation to know my Payor's requirements and ensure that they have been fulfilled. _______ **Initials**

- **I further understand** it is my responsibility to update my insurance information each time it changes. If I have provided incorrect insurance information and it precludes the

Practice from obtaining payment for services, I understand that the charges associated will be my responsibility. ______**Initials**

- **I understand and agree that I am financially responsible for any charges not covered by this assignment and agree to pay the Practice the full balance that is not reimbursed by my medical provider benefits (certain exceptions may apply for Medicare Beneficiaries). ______Initials**

- **I understand** that any and all balances assigned as patient responsibility may be subject to both internal and external collection efforts, as well as credit reporting to the three major credit bureaus if not paid in a timely manner. _______**Initials**

- **I understand if a scheduled appointment is missed without the minimum 24 hour notice, I will be charged a $25.00 "no-show" appointment fee. This is my sole responsibility and can not be billed to my insurance. ______Initials**
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Printed Name of Patient/Guarantor **Signature of Patient/Guarantor**

Date________________________ **ATTACH STICKER HERE**