PATIENT FINANCIAL RESPONSIBILITY STATEMENT

WellStar Physicians Group

South Cobb Primary Care Center

1680 Hospital South Drive
Austell, GA 30106
678-945-2100

Patient Name:_____ **Date of Service:** _____

Patient Account No: _____

Please check one of the following:

[ ] **I have presented evidence of valid insurance coverage, as of this date below, to WellStar Physicians Group.**

_____

Insurance Identification Number / Insurer's Name / PCP Name on Card

** Verification of benefits from your Insurance Company is not a guarantee services are covered or will be paid by your insurance company*

[ ] **Self-Pay. I have not presented any evidence of insurance coverage. I understand that I am financially responsible for all charges incurred for services provided. I understand that payment is due at the time services are rendered and I possess the means to tender payment today.**

Please circle intended method of payment: Cash Check Credit Card

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

- **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 Group 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** that any payment received by the Group for this period may be applied to any unpaid bill(s) for which I am liable.
- **I understand** that different Payor's 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.
- **I understand and agree that I am financially responsible for any charges not covered by this assignment and agree to pay the Group the full balance that is not reimbursed by my medical provider benefits (certain regulations and exceptions apply for Medicare Beneficiaries).**
- **Additionally**, if the Group elects to pursue an appeal of any denials by my Payor of the payment for services rendered, this Statement constitutes written consent that Facility 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 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.
- **I understand there is a $25.00 fee for missed appointments without prior notification.**

_____ _____

(Patient/Guarantor Signature) **(Date)**

** NOTE: If you provided us with insurance information today, 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 Group for reimbursement of services provided. ** Please contact the number above for more information regarding financial assistance or payment plan options that may be available to you.*