Patient Financial Responsibility Statement

Thank you for choosing our practice for your healthcare needs. It is our goal to provide you with the highest quality healthcare services as possible. We ask that you please read and understand your financial responsibilities prior to booking your appointment and receiving services.

1. I understand that I am responsible for knowing the policy provisions and rules of my insurance coverage(s) and that I am solely responsible for obtaining any necessary referrals prior to my appointment. Failure to obtain and present a valid referral may result in my being financially responsible for all services provided.

2. I understand that I am financially responsible for any amount not covered by my insurance including, but not limited to, co-pays, co-insurances, deductibles, and non-covered services.

3. I understand that if I do not have valid medical insurance, I am financially responsible for all fees for provision of medical services and that, unless other arrangements have been made in advance in writing, payment of these fees is expected in full.

4. I understand that failure to remit payment for any amounts deemed patient responsibility may result in my account being referred for collection activity and that I will be financially responsible for any additional fees incurred as a result.

5. I understand that any appointments missed, but not cancelled prior to the appointment time, may result in my being charged a Missed Appointment Fee of $25 per missed visit.

6. I understand that I will be charged $35 for any check returned by my bank for any reason.

Assignment of Benefits

I hereby authorize any insurance carrier, including Medicare, to make payment directly to MD Medical Group for any services rendered to me or my covered dependents of any amounts otherwise payable to me toward the reimbursement of any medical expenses incurred at this facility**. I understand that I am financially responsible for payment of all services regardless of any payment issued by my insurance or not.**

I Agree that by checking the box while making my appointment online shall be considered my agreeing to all terms of this Patient Financial Responsibility Statement.

Release of Medical Records and Information

I hereby authorizes the release of any Protected Healthcare Information (PHI) to any involved insurance company, or their authorized third parties involved in my case unless I have specifically instructed otherwise.

This Patient Financial Responsibility Statement is subject to change at any time. For the most up to date version, please email support@TestHere.com and we will be happy to send it to you.