PATIENT FINANCIAL AGREEMENT

Patient Name: _____ Account Number: _____

Patient Information:

Date of Birth: _____

Address: _____

Phone Number: _____

Email Address: _____

Guarantor Information (if applicable):

Full Name: _____

Relationship to Patient: _____

Phone Number: _____

Email Address: _____

Financial Responsibility and Payment Terms:

The undersigned agrees to be financially responsible for all charges incurred for medical services rendered by the provider(s). Payment

Accepted forms of payment include cash, check, credit/debit cards, and electronic payments. The patient/guarantor understands that fai

Insurance Information (if applicable):

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____

Insured's Name (if different): _____

1. Acknowledgment of Financial Responsibility

Patient/Guarantor acknowledges that they are responsible for payment of all charges for services received, including any portion not covered by insurance. Patient/Guarantor agrees to pay all co-payments, co-insurance, deductibles, and amounts for non-covered services.

2. Insurance Assignment and Release

Patient/Guarantor authorizes the provider to file claims with the insurance company and assign benefits payable for services rendered directly to the provider. Patient/Guarantor authorizes release of any medical or other information necessary to process insurance claims.

3. Payment Terms

Payment is due upon receipt of billing statements. If payment is not made within a reasonable time frame, accounts may be referred to a collection agency. Patient/Guarantor agrees to pay all costs and fees associated with collection efforts, including attorney's fees where permitted by law.

4. No Guarantee of Insurance Coverage

Patient/Guarantor understands that insurance benefits are not guaranteed and are subject to the patient's coverage terms. Patient/Guarantor agrees to pay any amounts denied by insurance.

5. Cancellation and Missed Appointments

Patient/Guarantor agrees to notify the provider at least 24 hours in advance to cancel or reschedule appointments. Provider reserves the right to charge fees for missed appointments or late cancellations as permitted by law.

6. Privacy and Confidentiality

Patient/Guarantor acknowledges receipt of the provider's Notice of Privacy Practices and understands that their personal and health information will be handled in accordance with applicable privacy laws.

7. Governing Law

This Agreement shall be governed by and construed in accordance with the laws of the State of _____ without regard to its conflict of law provisions.

8. Dispute Resolution

Any disputes arising under this Agreement shall first be subject to informal negotiation. If unresolved, disputes shall be submitted to mediation. If mediation fails, either party may pursue legal remedies in a court of competent jurisdiction.

9. Severability

If any provision of this Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and effect.

10. Entire Agreement

This document constitutes the entire agreement between the parties regarding financial responsibility for medical services and supersedes all prior agreements or understandings.

11. Patient/Guarantor Certification

By signing below, Patient/Guarantor certifies that they have read, understand, and agree to the terms of this Patient Financial Agreement.

PATIENT / GUARANTOR SIGNATURE	**PROVIDER REPRESENTATIVE SIGNATURE**
Signature: _____	Signature: _____
Print Name: _____	Print Name: _____
Date: _____	Date: _____