PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing mainland pulmonary associates as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies, which are as follows:

- To pay for the co-pay or any additional co-insurance at the time of service. We may at times collect co-insurance at the end of the visit for any additional tests that are ordered.
- To know the insurance policy. Patients should be aware of their benefit coverage including which physicians are contracted with their plan, covered and non-covered benefits, authorization requirements, and costs share information such as deductibles, co-insurance, and co pays. If you are not familiar with your plan coverage, we recommend that you contact your carrier directly.
- To pay any Medicare deductible and co-insurance not covered by their supplemental insurance.
- To obtain a referral from their Primary Care Physician (PCP) and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- Patient statements are mailed monthly. The patient is responsible for making a payment, or for arranging a payment plan, within 30 days of the date that appears on his/her patient statement.

FINANCIAL POLICY ACKNOWLEDGEMENT:

I have read and understood the above financial policy. I understand that regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I understand that payments can be made by cash, check, MasterCard, Visa or amex.

Signature of Patient or Guardian: _____
Name of patient:_____
DATE: _____