PEDRO M. ARGUELLO, M.D. PA

PATIENT'S FINANCIAL RESPONSIBILITIES

We have developed financial policies to promote confidence and understanding between our patients and our practice. In addition to supplying quality medical care, we are committed to providing the best possible service, including but not limited to a complete understanding of your financial responsibilities.

PATIENT'S NAME:_____ DATE:_____

RESPONSIBLE PARTY (NAME) :_____ DATE:_____

- **I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments/deductibles are due at time of service**. In the event that my health plan determines a service to be **"not payable",** I will be responsible for the complete charge and agree to pay the costs of all services provided.
- **HMO/Manage Care Patients:** It is the responsibility of the patient to ensure that they have obtained a referral for all appointments with this office, if needed. The patient is responsible for any and all services rendered that are not part of the referral. If you did not get a referral for our services, you will be required to pay the full amount of all services.
- Please understand that your insurance coverage is entirely up to the insurance plan you fall under. Should you have any questions or concerns over your coverage, please call your respective insurance company.
- It is the responsibility of the patient to have their insurance information with them at the time of visit and to notify the practice of changes in insurance coverage.
- If your insurance can not be verified at the time of the visit, the practice will be forced to collect full payment for the visit.
- **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS** I hereby authorize and direct payment of my medical benefits to Pedro M. Arguello, M.D. PA on my behalf for any services furnished to me by the provider.
- **AUTHORIZATION TO RELEASE RECORDS** I hereby authorize Pedro M. Arguello, M.D. PA to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.
- **Missed Office Visit Appointments without notification (No show's) will be a $50.00 Charge.**
- **Missed Appointment for Procedures: will be a $100.00 charge. Payment for procedures (if applied) must be made within 48 hours of appointment. No shows for procedures in ordered to be reschedule a pre-payment will be required.**

I Have read and understand all of the above information and financial responsibilities:

_____ _____ _____

Signature Print Name Date