PATIENT FINANCIAL RESPONSIBILITY

Patient Name: AHN MD, ANTHONY

VERIFICATION OF INSURANCE COVERAGE

Please initial.

____It is my responsibility to know the benefits, limitations and exclusion of my individual insurance plan. ***Verification/Authorization of coverage is not a guarantee of payment and BCO is not responsible if information provided is incorrect.***

FINANCIAL RESPONSIBILTY AND ASSIGNMENT OF BENEFITS

Please initial.

____I am responsible for any unpaid balance, **regardless of any insurance coverage.** I assign all medical benefits to which I am entitled to be paid directly to Beach Cities Orthopedics. In the event payment is made directly to me, I agree to promptly remit payment to this office. If legal action becomes necessary to collect payment, I am responsible for all costs incurred, including collection agency and legal fees.

DEDUCTIBLES, CO-PAYS AND COINSURANCES

Please initial.

____**My co-pay is due at the time of service** unless prior financial arrangements have been made. We will bill your insurance for the balance of services provided as a courtesy.

CASH PATIENT

Please initial.

____**Payment in full is due at time of service** unless prior financial arrangements have been made.

I have read and fully understand the above information and agree to comply as outlined above.

03-23-2016

Patient Signature (if minor, parent's signature) **Date**