



FEMALE HEALTH ASSOCIATES OF NORTH TEXAS
A PROFESSIONAL ASSOCIATION

Financial Responsibility Agreement

Patient Name: _____ DOB: ____/____/____ Date of Visit: ____/____/____

I, _____, understand that I will be financially responsible for any and all charges for services not paid by my insurance visits. This includes any Medical service or visit, Preventative exam or physical, Lab testing, X-Ray, EKG, and any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance company will pay for my Medical service visit, Preventative exam or physical, Lab testing, X-ray, EKG, or any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provided is not recognized by my insurance company or plan, it may result in claims being denied or higher out-of-pocket expenses to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

I am also aware that there may be additional fees that are not covered by my insurance company. There will be a check fee of \$25.00 for all returned checks. Failure to cancel a regular appointment with less than 24 hours notice or not showing for an appointment is subject to a \$35.00 charge. Failure to show for an in-office procedure where adequate time has been set aside will result in a \$50.00 charge. Also, completion of medical forms not covered by the insurance company is \$25.00 for the first set and \$10.00 for each additional set (FMLA).

Signature: _____

Date: _____

Print Name: _____

Witness: _____