2721 Shoreline Drive, Suite 120
Denton, TX. 76210
Phone: 940-205-6584
Fax: 940-324-0633

Website: www.ConnectionsPrimaryCare.com

Statement of Patient Financial Responsibility

Patient Name: _____ Date of Birth: ____/____/_____

Connections Primary Care appreciates the confidence you have shown in choosing us to provide for your health care needs. The services in which you have elected to participate imply a financial responsibility on your part and obligate you to ensure full payment for services rendered. As a courtesy, we will bill your primary insurance carrier on your behalf; however, you are ultimately responsible for full payment of your bill.

Many insurance companies have additional stipulations that may affect your coverage. **It is your responsibility to know and understand your insurance coverage and benefits**. You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your balance in full. It is your responsibility to obtain appropriate referrals or authorizations required by your insurance carrier to be seen at Connections Primary Care.

___ I authorize Connections Primary Care to furnish information to my insurance carrier related to my care.

If additional diagnostic tests or labs are ordered and performed outside the clinic, you may incur additional charges over and above those for services from Connections Primary Care. You are financially responsible for these additional charges. Full payment for services provided by Connections Primary Care is due at the time service is rendered otherwise additional fees and interest may be charged.

___ If payment is denied for lack of authorization, I understand that I am responsible for payment in full.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We will collect these payments at the time of service.

___ I understand that I am responsible for co-payments and deductible/co-insurance as required by my insurance carrier.

CONNECTIONS
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I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay, I will also be responsible for interest, collection fees, court costs, attorney fees, and any other charges incurred in the collection of any balance due.

Cancellation/No Show Policy

We understand there may be times when you are late or miss an appointment because of emergencies or obligations to work or family. It is an expectation that you notify the office at least 30 minutes before your scheduled appointment time to cancel or reschedule your appointment.

I have read the above policy regarding my financial responsibility to Connections Primary Care for providing medical services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Connections Primary Care. I understand that any amount remaining after such payment has been made by my insurance carrier becomes my responsibility.

_____ _____

Signature of patient OR parent/guardian if under the age of 18) Date

_____

Printed Name

_____

Relationship to patient (if not the patient)