FINANCIAL RESPONSIBILITY AGREEMENT
POLICIES, DISCLOSURES, AND CONSENTS

ARROYO VISTA
FAMILY MEDICINE

Patient Name:_____ **DOB (Date of Birth):**_____

INSURANCE INFORMATION (Please fill out SECTIONS 4-6 even if you are providing your insurance card(s)):

PRIMARY INSURANCE	**1. Insurance Company:**	**2. Policy ID Number:**	**3. Group ID Number:**
	4. Policy Holder's Name: ☐ Self (if self, skip 5-6)	**5. Relationship to Patient:**	**6. Policy Holder's DOB:**
SECONDARY INSURANCE	**1. Insurance Company:**	**2. Policy ID Number:**	**3. Group ID Number:**
	4. Policy Holder's Name: ☐ Self (if self, skip 5-6)	**5. Relationship to Patient:**	**6. Policy Holder's DOB:**

Please read and initial the following disclosures and consents to ensure you understand and agree to them:

PATIENT'S ROLE IN VERIFYING INSURANCE COVERAGE:
I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or 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.
Patient's Initials: _____

PATIENT'S ROLE IN VERIFYING INSURANCE DEDUCTIBLE/CO-PAYMENT/CO-INSURANCE:
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.
Patient's Initials: _____

PATIENT'S ROLE IN VERIFYING IN-NETWORK AND OUT-OF-NETWORK PROVIDERS:
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 provider I am seeing 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.
Patient's Initials: _____

HMO-INSURED PATIENT'S ROLE IN VERIFYING PRIMARY CARE PHYSICIAN (PCP):
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.
Patient's Initials: _____

HMO-INSURED PATIENT'S ROLE IN VERIFYING REFERRALS FROM PRIMARY CARE PHYSICIAN (PCP):
I understand and agree it is my responsibility to know whether my referral to see Samuel Landero, MD, PA in the management of Obesity/Bariatric Medicine and co-morbidities has been processed by my insurance company or plan. If a referral has been requested on my behalf and 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.
Patient's Initials: _____

MEDICARE/MEDICAID/CHAMPS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Samuel Landero, MD, PA or the physician on my behalf.
Patient's Initials: _____

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.
Patient's Initials: _____

FINANCIAL RESPONSIBILITY FOR CHARGES/SERVICES NOT PAID BY INSURANCE:
I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical, lab testing, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.
Patient's Initials: _____

FINANCIAL RESPONSIBILITY FOR NO SHOW/MISSED APPOINTMENT FEE(S):
I understand and agree that I will be financially responsible for any fees incurred as a result of any no show/missed appointments as detailed by the No Show/Missed Appointment office policy. I understand that no show/missed appointment fees are not paid by my insurance.
Patient's Initials: _____

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Samuel Landero, MD, PA or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Samuel Landero, MD, PA is unable to collect from my insurance carrier for whatever reason.
Patient's Initials: _____

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the Samuel Landero, MD, PA's Patient Information Privacy Policy. I hereby authorize Samuel Landero, MD, PA or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.
Patient's Initials: _____

CONSENT TO TREATMENT:
I consent to the administration and performance of treatment, use of prescribed medications, performance of diagnostic procedures, tests and cultures, and performance of other laboratory tests that my physician or his designee determines medically necessary or advisable based on the judgment of my physician or their assigned designees. I give this consent in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in force until revoked in writing; and a revocation of this consent will not affect the validity of my consent as to acts performed prior to the revocation. I understand that while my consent is voluntary, if I refuse to sign this consent, Samuel Landero, MD, PA may refuse to treat me.
Patient's Initials: _____

By signing my name below, I certify that I have read the above information. Any questions concerning this agreement have been discussed. My signature also certifies my understanding of and agreement with the above policies. I understand I am responsible for all charges not paid by insurance. A photocopy of this document is as valid as the original and may receive a copy of this document upon request.

_____ _____
Signature of Patient, Parent, or Legal Guardian **Date**

If the guarantor is different from the Patient/Parent/Legal Guardian, please fill out the following:

_____ _____ _____
Guarantor's Name **Guarantor's DOB** **Guarantor's Relationship to Patient**