☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Patient Name: ____ DOB: ________________________

The medical services that are being rendered today may not be covered by your insurance company for one of the following reasons. This does not mean that you cannot receive medical services. By signing this Financial Responsibility Acknowledgement, you acknowledge full responsibility for today's charges.

- Services rendered may not be considered eligible for benefits by your health plan.
- We are unable to verify benefits or confirm eligibility by your health plan due to after hours or insurance card not present.
- You are assigned to another PCP (Primary Care Physician) or IPA (Independent Practice Association).
- We do not have the required referral /authorization for today's visit.
- We are contracted with your primary insurance; however, we are not contracted with your secondary insurance.
- Services may be considered out of network.
- Financial Agreement: The undersigned agrees, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to promptly pay the account in accordance with the regular rates and terms. Should any account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.
- Assignment of Insurance Benefits: The undersigned assigns and authorizes direct payment to the Hoag entity selected above and affiliates of any insurance benefits otherwise payable to or on behalf of the patient for these outpatient services. It is understood by the undersigned that he/she is financially responsible for charges not paid according to this assignment.
- Health Plan (Insurance) Obligation: It is the patient's obligation to assure that the patient's health plan has authorized the services to be provided.
- It is the responsibility of the undersigned to determine if physicians providing services to the patient contract with the patient's health, if any.

All charges that have been explained to you are based on "Good Faith" estimate.

I understand that my health insurance coverage has certain restrictions and limitations such as authorization requirements, non-covered services, and/or no out of network benefits. Since I have chosen to obtain the services rendered today, I agree to be financially responsible for any and all related charges if they are not covered by my insurance.

Patient/Legal Representative Signature: ________________________________ Date/Time: ______________

If signed by other than patient, indicate relationship: ____

Print Name – Legal Representative: ____

Staff Signature: ____ Date/Time: ______________

CONSENT FORM

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PATIENT LABEL