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ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY & CREDIT CARD AUTHORIZATION FORM

We require every patient to read the following agreement before provision of care.

If you do not have health insurance or if our office is not contracted with your health insurance plan you will be required to pay all charges, in full, at the time of your visit.

It is your responsibility to provide us with complete, accurate, and up-to-date information in order for us to successfully bill your insurance company, and to find out whether we are considered an in- network provider for your health plan before services are rendered.

We will always bill your insurance company first and await their response before sending you an invoice. If your insurance company pays your medical services in full, you will not receive a bill from us. If there is a remaining balance present due, we will send you an invoice promptly.

Our office requests a copy of your credit card to keep on file so as to avoid your account being referred to a collection agency for any outstanding balances past our 90 day grace period.

If you have any questions regarding your benefits we encourage you to call your insurance company.

Please present your credit card with paperwork to our front desk.

Acknowledgment:

I, ……. (print your name)

understand and agree that it is my responsibility to pay any outstanding balances. I authorize David Bjelica MD a Medical Corporation to charge my credit card for any remaining unpaid balance.

Signature: …….Date: …….....