Financial Responsibility / Waiver Form

Dear Patient:
Positive verification of your coverage cannot always be made at the time of service. You will receive services with the understanding that in the event your coverage is not effective, or that services are denied, you will be billed and held financially responsible for these services rendered. You will also be billed with the understanding that if collection services are required to recover these balances, they will be subject to a collections fee of 40% of the balance.

I have read the above and understand my possible financial responsibility of services rendered and hereby affix my signature as an acknowledgment of this understanding.

_____

Patient Name-Print

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Patient's Signature Date