Patient Responsibility & Insurance Information

Patient's First Name	Patient's Last Name	MI

INT.	1. **I understand and agree that I will be financially responsible for all charges for services not paid by my insurance for my visits.** This includes any medical service or visit, preventive exam or physical, lab testing, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.
INT.	2. **I understand and agree it is my responsibility - and not the responsibility of the Physician or Office - to know if my insurance will pay for my medical services,** including the office visit, preventive exam or physical, lab testing and any other screening service or diagnostic testing ordered by the physician or the physician's staff.
INT.	3. **I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment,** co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment whenever required.
INT.	4. **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 is not recognized by insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.
INT.	5. **I understand and agree it is my responsibility to know if my PCP (primary care physician) choice had 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.
INT.	6. **I understand that the physician may charge a $30.00 fee if I do not show up for my appointment or cancel without a 24-hour notice. This fee will not be charged to insurance and will be the patient's responsibility.**
INT.	7. **I understand that if I need a copy of my medical records, a $10 printing fee will be charged. This fee <u>will not be charged to insurance</u> and will be the patient's responsibility.**
INT.	8. **I understand that any forms to be filled out by the physicians will have a $15 fee assessed.** This fee does not apply if forms are filled out as part of a scheduled office visit. This fee will not be charged to insurance and will be the patient's responsibility.
INT.	9. **I understand that I will be required to provide a valid form of payment, either cash, check or credit card which will be run electronically.**
INT.	10. **I understand that any account balance that is 90 days past due will be sent to collections unless other arrangements have been made directly with Crazy Mountain Family Medicine** and that <u>it is my responsibility to ensure that my insurance and contact information is always current and updated.</u>

I, the undersigned, hereby authorize and direct my insurance carrier to pay directly to:

Michelle Lizotte, MD and Crazy Mountain Family Medicine all insurance benefits, if any, due to me under my insurance plan. Furthermore, I agree to pay the balance of the charges not paid by my insurance that are considered patient responsibility, such as co-pays and deductibles. I hereby authorize the release of any information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions. If the patient is a minor, I as a legal guardian give consent for treatment for this and future services rendered. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____

Patient's Signature ~ or ~ **Signature of the Responsible Party* **Today's Date**

*If a Responsible Party is signing, please print name here _____

*How is the Responsible Party related to the patient? _____

OFFICE USE ONLY:

Copy of Insurance Card here