

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

In order to for Alliance Medical Group (“AMG”) to maintain our fees at the lowest possible rate, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to ask any questions you may have.

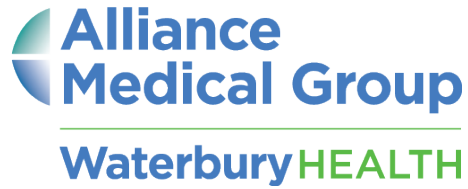
- You must pay any co-payment and applicable deductible amounts due at the time of service. We accept Cash, Checks, Visa, MasterCard, Discover and American Express. There will be a \$12.00 charge for all returned checks. Fee is subject to change without notice.
- If you are not insured, or if the services are not covered by your insurance, you are expected to provide full payment at the time services are rendered. AMG has income based financial assistance paperwork that will be given upon request.
- AMG will bill your insurance company as a courtesy. Please understand that the financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.
- In those instances where we have a participating provider agreement with your insurance company for an agreed upon negotiated rate for our services, an adjustment will be made in the amount of the difference between this rate and our normal fees at the time we receive payment from your insurance company. You will remain responsible for required co-payments, applicable deductibles and any services that are not covered by your insurance plan.
- If, by mistake, your health plan remits payment to you, please deposit the check from your insurance company and send a personal check to our billing company along with all paperwork received from your insurance company. Mail check and paperwork to.

Prospect Connecticut Medical Foundation

1801 W. Olympic Blvd File 2201

Pasadena, CA 91199-2201

- Your health plan may refuse payment of a claim for some of the following common reasons. This is not an all-inclusive list; please check with your insurance company should you have any questions.
 - This is a pre-existing illness that is not covered by your plan.
 - You have not met your full calendar year deductible.
 - The type of medical service required is not covered by your plan.
 - The health plan was not in effect at the time of service.
 - You have other insurance which must be filed first.
- Any patient who fails to arrive for a scheduled appointment without cancelling the appointment prior to the scheduled time is considered a “no-show”. A no-show patient may be charged \$25.00, as set by the Practice, for failure to show. A patient, who is a no show three times, within a 12 month period, may be dismissed from the Practice. We ask that a 24 hour courtesy be given for all cancellations.
- Patient balances not paid after 90 days may be sent to a collection agency. Unpaid outstanding balances are subject to AMG’s discharge policy.



I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered or approved by my insurance carrier.

Patient Date of Birth (MM/DD/YYYY): ____/____/____

Patient Print Name

Patient Signature

Date

Legal Representative Print Name

Legal Representative Signature

Date

Relationship to Patient: Parent Legal Guardian Power of Attorney Other: _____