ADVANCED PACIFIC

FINANCIAL RESPONSIBILITY FORM

Please remember that insurance is considered a method of reimbursing the doctor. Some companies pay fixed amounts for certain procedures, and others pay a percentage of the charges. It is your responsibility to pay any deductible, copay or any other balance not paid by your insurance company.

We request that charges for office visits be paid the day of the visit by either check, cash or credit card. There is a service fee of $35 on all returned checks. Advanced Pacific does not accept American Express.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. Our staff is here to assist you, but understanding your policy benefits as well as limitations remains your responsibility.

If you have an insurance plan we do not participate with, we will provide a claim to you, which you may submit to your carrier on an unassigned basis. This means your insurance plan will send the payment directly to you. Therefore, all charges for treatment are due at the time of service. We do not participate with Worker's Compensation, Motor Vehicle Accident or Third-Party liability claims.

If this account is assigned to an attorney for collection or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize the disclosure of my medical records to my insurance carrier. I hereby assign all medical and surgical benefits to which I am entitled, including Medicare, private insurance and other health plans to Advanced Pacific. The assignment shall remain in effect until revoked by me in writing. A photocopy of this original assignment is to be considered as valid as the original. I understand that I am financially responsible for charges whether or not paid by insurance. I hereby authorize Advanced Pacific to release all information necessary to secure payment. I understand that it is my responsibility to provide the office with my current and correct insurance information. If I fail to do so, I am responsible for paying in full for services rendered.

Signature of Responsible Party: _____ Date: _____

If signing as the responsible party, what is your relationship to the patient? _____