PATIENT FINANCIAL RESPONSIBILITY

Patient Name: _____

VERIFICATION OF INSURANCE COVERAGE
Please initial.
____ It is my responsibility to know the benefits, limitations, and exclusions of my individual insurance plan. **Verification/Authorization of coverage is <u>not</u> a guarantee of payment and BCO is not responsible if information provided is incorrect.**

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS
Please initial.
____ I am responsible for any unpaid balance, **regardless of any insurance coverage**. I assign all medical benefits to which I am entitled to be paid directly to Beach Cities Orthopedics. In the event that payment is made directly to me, I agree to promptly remit payment to this office. If legal action becomes necessary to collect payment, I am responsible for all costs incurred, including collection agency and legal fees.

DEDUCTIBLES, CO-PAYS, AND COINSURANCES
Please initial.
____ **My co-pay is due at the time of service** unless prior financial arrangements have been made. We will bill your insurance for the balance of services provided as a courtesy.

AUTO INSURANCE PATIENT
Please initial.
____ I acknowledge that once my auto insurance med pay has been exhausted and/or insurance has been billed for all medical treatment, **any remaining unpaid portion will be paid in full by myself** regardless of any future legal representation and/or settlement amount received in connection with my injury from the accident.

CASH PATIENT
Please initial.
____ **Payment in full is due at the time of service** unless prior financial arrangements have been made.

I have read and fully understand the above information and agree to comply as outlined above.

_____ _____
Patient Signature (if minor, parent or guardian's signature) **Date**