PATIENT FINANCIAL RESPONSIBILITY

Our mission at **J. Gabriel Guajardo M.D., P.A.** is to provide the highest standard of healthcare, and to help our patients be informed regarding healthcare benefits. J. Gabriel Guajardo M.D., P.A. participates in most major health insurance plans to make care more accessible to you.

Thank you for choosing **J. Gabriel Guajardo M.D.** as your healthcare provider. We ask that you read and sign this Financial Policy prior to any treatment, service or procedure. Please let us know if you have any questions.

J. GABRIEL GUAJARDO M.D., P.A. RESPONSIBILITIES:

- Provide you and/ or your insurance company with a timely and accurate statement of all charges for services rendered.
- Fully explain all charges for services rendered and acceptable payment methods.
- Secure all pre-authorizations and /or referrals that your healthcare insurance requires a physician's office to obtain for your ongoing care or treatment.

PATIENT RESPONSIBILITIES: **PATIENT INITIALS:**_____

- Provide **J. Gabriel Guajardo M.D., P.A.** with proof of your current insurance information, valid photo identification, employment, and demographic information at the time of each visit. Notify us within (10) days if you have a change in insurance status or demographic data.
- Pay in full, the expected portion for the balance of your account at the time of service.
- Patients who do not have insurance coverage (or proof of coverage) are expected to pay in full at time of service. If you cannot pay the full amount of your bill, then you must make satisfactory payment arrangements with our billing department ***prior*** to receiving services.

ANCILLARY SERVICES: **PATIENT INTITIALS:**_____

- PLS (Physician Laboratory Services) is the preferred lab for **J. Gabriel Guajardo M.D., P.A .** When labs, x-rays or other tests are ordered by **J. Gabriel Guajardo M.D.** you are responsible to check with your insurance company as to where you are authorized to have these services performed. We WILL NOT be responsible for any bill if you have a test done at a non-preferred facility.

- Subsequent charges may be applied to account if additional tests are performed due to LAB test results (i.e. urine culture performed due to urinalysis results, HPV performed due to

- abnormal Pap Smear results, or Pap Smear interpretation performed due to abnormal Pap Smear results).

PATIENT INITIALS: _____

I hereby assign all payments for services rendered to me or my dependents to **J. Gabriel Guajardo M.D., P.A.** I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to insurance carriers concerning mu illness and treatment.

I have read and understand the financial policy of the practice, and agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____**Date**_____

Signature of Patient

_____

Printed Name

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