PORT RICHEY HEALTH CENTER

PRICARE LLC

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Port Richey health Center for your medical needs. We ask that you read and sign this form to acknowledge your understanding of our patient's financial policies:

Patient's Financial responsibilities:

- The patient (or patient's guardian, if a minor) is ultimately responsible for treatment and care
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedure or treatment not covered by their insurance plan
- **Copays are due at the time of service**
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges if applicable. These charges may include: Charges for returned checks $30.00
- **By my signature below, I hereby authorize assignment of financial benefit directly to Port Richey Health Center/ PRICARE LLC and any associated health entities for services rendered as allowed under standard third party contracts. I understand that I am financially responsible for charges covered by this assignment.**

Patient's Name:_____

Patient's/ Guardian's Signature:_____

Date:_____