Patient acknowledgement of financial responsibility

Thank you for choosing Primary Care & Hope Clinic as your healthcare provider. We are committed to providing you with the highest quality of healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

- The patient (patient's guardian, if a minor) is ultimately responsible for the payment of treatment and care.
- We will attempt to confirm your insurance coverage prior to your treatment. However, your benefits are a contract between you and your insurance company. As a courtesy, PCHC will attempt to file for payment from your insurance company.
- It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- Patients are personally responsible for knowing and understanding their own insurance policy, including co-payment, deductible, eligibility, and coverage. If you have questions regarding your coverage, please call your insurance company directly.
- Verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company upon receipt of the claim.
- Laboratory services are provided by AEL Laboratories. There may be additional charges for labs performed. Any questions about billing from AEL are to be resolved by contacting the lab company directly.
- If deductibles apply, you will be expected to make a $50 deposit at the time of service. We will bill any remaining deductible determined by your insurance company to you.

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Print Name | Date of Birth

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Signature of Patient or Legal Guardian | Today's Date