Affiliates In Internal Medicine

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Please fill out top half of for-Thank You

Acknowledgement of Financial Responsibility

As your healthcare provider, I want to provide you with the best possible care. There are services that I feel are in your best interest for the treatment of your condition and maintenance of good health that may not be covered by your health insurance coverage or may be applied to your deductible and/or co-insurance. You will be expected to pay for those services in full. Let me reassure you that I will only provide care that I feel is necessary.

Due to all the healthcare changes some insurance my apply different services we perform towards patient liability.

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. I understand that by signing this form, I will be fully responsible for the total billed charge(s) related to non covered services and/or patient liabilty for routine services.

Patient's Signature: ______________________________ **Date:** ______________

Non-Covered Services Disclosure Form

I, ______________________________ have chosen to receive the following service that is not
(patient's name)
covered by my health plan and I agree to pay the full charge(s) for the following service(s):

Service:______________________________ **Services Cost:**______________________________

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services havealready been provided. I understand that by signing this form, I will be fully responsible for the total billed charge(s) related to noncovered services.

Patient's Signature: ______________________________ **Date:** ______________