



**EPN: FINANCIAL RESPONSIBILITY FORM**

Erie Physicians Network, PC      January 4<sup>th</sup>, 2010

**Consent to Services:**

Patient hereby requests registration at an Erie Physicians Network, PC (referred to as EPN, PC in this document) office and voluntarily consents to any facility services deemed necessary or advisable as determined as appropriate by the attending physician or his or her assistants/designees, or employees or agents of EPN, PC, with appropriate clinical privileges. Patient (responsible party) acknowledges that no guarantees have been made as to the results of treatment or examination at the EPN, PC office.

**Payment Guarantee:**

For and in consideration of services rendered by the EPN, PC office, patient (responsible party) hereby agrees to and guarantees payment of all charges incurred for the account of the patient. Payment is due in full prior to the service being rendered. We accept cash or credit card.

If the patient is eligible with an EPN, PC participating insurance company and identification is provided, the insurance company will be billed for the services rendered in lieu of cash payment by the patient (responsible party); copays and deductibles to be paid prior to the service.

**Consent to Release Information:**

The undersigned hereby authorizes the EPN, PC office to release to employer group, insurance companies, government agencies or other third party payers and their agents information concerning diagnoses and procedures performed, medical care, advice, treatment, supplies or other information that may be necessary for the purpose of determining eligibility and available benefits and obtaining payments on the patient's behalf for the health care services rendered to the patient. Patient (responsible person) acknowledges that he or she will be financially responsible for charges incurred for the patient's treatment if revocation or refusal to authorize the disclosure of the medical records results in a payment denial of the insurance claim.

**Medicare:**

Patient certifies that the information given in applying for payment under Title XVIII (18) of the Social Security Act is correct. Patient (responsible party) authorizes any holder of medical or other information about patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medical claim. Patient (responsible party) requests that payment of authorized benefits be made on his/her behalf to the name of provider of service for any services furnished to the patient by that provider of service.

**Medigap/Secondary Insurance:**

Patient (responsible party) requests that payment of authorized Medigap benefits be made on patients behalf to the provider of service for any services furnished to patient by that provider of service. Patient (responsible party) authorizes any holder of Medicare information about patient to release to

(Medigap Name) any information needed to determine these benefits payable for related services.

**Assignment of Insurance Benefits and Agreement to Pay at the time of service:**

Patient (responsible person) irrevocably assigns and transfers to EPN, PC all right, title and interest to medical reimbursement benefits under any and all applicable medical insurance policies covering patient, for the payment of hospital and medical care being provided. Patient (responsible person) authorizes payment directly to EPN, PC of said medical reimbursement benefits. In the event that said medical insurance coverage is not sufficient to satisfy the charge in full, patient (responsible person) acknowledges that the resulting balance is not covered by this assignment and agrees to be fully responsible for the payment of any balance due. If the insurance is a non-contracted payer, EPN will submit a courtesy claim, however the balance will always remain the patient's responsibility until the claim is paid. If the patient does not have medical insurance, the balance will be deemed to be "patient responsible" and is due prior to the time of service. Patient (responsible person) acknowledges responsibility for any expenses incurred by EPN, PC for collecting any of the charges incurred on the account of the patient. Such shall specifically include any attorney's fees or any collection fees, or litigation and/or audit costs incurred by Erie Physicians Network on collecting said bill. A \$50.00 fee will be charged for missed appointments and appointments cancelled less than 24 hours in advance

*These agreements and authorizations shall be valid for one (1) year from the date of patient/parent/guardian signature.*

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Patient Name (Last, First, MI) (print)

Health Insurance Claim Number

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*Patient Signature (Parent/Guardian)*

*Medigap Policy Number*

*Date*

*Please check the appropriate description of your relationship to the patient:*

\_\_\_\_\_ *Self*  
*(please explain)*

\_\_\_\_\_ *Parent/Legal Guardian of Minor*

\_\_\_\_\_ *Other*

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