



Aguilar Family Health Care
Statement of Patient Financial Responsibility

Patient Name: _____ **DOB:** _____

Aguilar Family Health Care appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

Effective January 1, 2011 Aguilar Family Health Care will implement a Collection Fee, to any unpaid account sent over to collections.

I have read the above policy regarding my financial responsibility to Aguilar Family Health Care, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Aguilar Family Health Care, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____

(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ Date _____

Consent for Treatment and Authorization to Release Information

I hereby authorize Aguilar Family Health Care, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize , Aguilar Family Health Care to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand, effective January 1, 2010 Aguilar Family Health Care will be implementing a \$25.00 fee for Canceling an appointment with less than 24hrs notice which includes no shows and walk outs, to cover our administrative costs.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

Aguilar Family Health Care, will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Aguilar Family Health Care. I agree to pay Aguilar Family Health Care, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ Date _____