HOLY REDEEMER PHYSICIAN SERVICES
CONSENT FOR FINANCIAL RESPONSIBILITY

Patient Name: _____

It has been explained to me and I understand that I will be financially responsible for any patient balance due under the following provisions:

___ Co-Pay Due/Deductible Not Met/Co-insurance Due

I understand that I will be financially responsible for all co-pays due for services provided or if my deductible has not yet been met or if there is a co-insurance due.

___ Non-Covered Services

I agree to be responsible for any professional charges incurred for a non-covered service for which my health plan will not make payment.

___ Enrollment Not in Effect/No Health Insurance

I understand that I will be financially responsible for all professional charges incurred if service was provided when my enrollment in a health plan was not in effect or if I have no health insurance.

_____ _____

Patient's Signature (Parent or Guardian if Patient is a Minor) Date

_____ _____

Witness of Signature (Practice Site Staff Member) Date