

**HealthCare for Business**  
**Statement of Patient Financial Responsibility**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

HealthCare for Business 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 bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

Due to the many changes in Insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you to please check with your insurance company prior to any office visit, procedure, or lab testing. **It is your responsibility to know your individual coverage.** Failing to comply with this suggestion could result in you, the patient, being held responsible for all costs incurred.

We **DO** know that we will not be reimbursed for Wellcare, Anthem, or Kaiser. If you have these insurance plans, **STOP NOW**.....you will need to reschedule with a doctor in your network. Please remember, your insurance policy is between you and your insurance company and **not between the insurance company and your doctor.**

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.

I have read the above policy regarding my financial responsibility to HealthCare for Business for providing my medical care. 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 HealthCare for Business/ Paul C. Hanahan, MD 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 HealthCare for Business / Paul C. Hanahan, MD., through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize HealthCare for Business / Paul C. Hanahan, MD., 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 if no show for three appointments or cancel for a total of four appointments, I may be discharged from care. After the first no show, I will be charged \$25.00 per no show.

HealthCare for Business 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 HealthCare for Business. I agree to pay the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

**Motor Vehicle Insurance (PIP)**

I have been involved in a Motor Vehicle Accident and I request my claims be submitted to my motor vehicle carrier. I understand I will be responsible for bills incurred by me in the event my PIP benefit exhausts or denies. Healthcare for Business will attempt to file claims with your personal insurance if the Motor Vehicle Insurance denies, however, I will be ultimately responsible for the bill if the personal insurance then denies for timely filing or any other reason.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

**Bureau of Worker's Compensation**

I have been involved in a work related injury and I request my claims be submitted to the BWC. I understand I will be responsible for bills incurred by me in the event the BWC disallows or denies the claim. Healthcare for Business will attempt to file claims with your personal insurance if BWC denies, however, I will be ultimately responsible for the bill if the personal insurance then denies for timely filing or any other reason.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_