Amarillo Colon & Rectal Clinic

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing **AMARILLO COLON & RECTAL CLINIC** for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of treatment and care.

We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.

Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.

Copays are due at the time of service.

Coinsurance, deductibles and non-covered items are due at the time the procedure is scheduled.

Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:

- Facility Fees
- Anesthesia Fees
- Pathology Fees
- Laboratory Fees

By my signature below, I hereby authorize assignment of financial benefits directly to **AMARILLO COLON & RECTAL CLINIC** and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Name _____

Patient/Guardian Signature _____

Date _____