Genesis Family Care, P.A.
Elizabeth Alvarez, M.D., P.A.

Financial Responsibility

I understand that all charges for services are due at the time of service, unless prior arrangements have been made in advanced. I understand that I am responsible for paying my co-payment, co-insurance or deductible as established by my insurance carrier on the day of my visit. I also understand that I will be responsible for all fees not covered by my primary or secondary insurance.

I am also aware that there will be a $30 charge for all returned checks. I understand that I am responsible for cancelling any appointment I make within 24 hours in advance otherwise I will be charged a fee of $25. If I should request a copy of my medical records, I understand that there will be a fee to process this request and that I must pay in advance. I understand that the processing of medical records can take up to 2 weeks from my request.

I authorize, Elizabeth Alvarez, M.D., P.A., and Genesis Family Care, P.A., to provide or release all necessary information regarding my medical treatments or visits to my insurance carrier in order that all my insurance claims can be processed adequately.

I affirm that I am the responsible financial party for myself or my dependents and understand that all fees are due on the day of service. I agree to pay these charges in full immediately after being requested for them during my visit.

_____ _____

Patient or Responsible Party's Name Date

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Patient or Responsible Party's Signature