ConnextCare™
A Community of Care

PATIENT RESPONSIBILITY AGREEMENT

Date of Service: _____ Primary Physician: _____

Member Name: _____ Date of Birth: _____

Insurance Company: _____ Member ID Number: _____

I am aware that I am financially responsible for today's visit if for any reason my insurance does not pay for it. Some possible reasons for non-payment include, but are not limited to:

1. No longer insured
2. Non-covered service through your primary insurance and/or Medicaid
3. ConnextCare is not my primary care provider
4. Accurate proof of coverage not provided within 90 days
5. Not Medicaid\Managed care eligible
6. ConnextCare does not participate with my insurance carrier

Some insurance companies require its members to have a referral in order to receive care and services from a provider who is not the member's primary care physician or a physician covering for that primary care physician. If your primary care physician has not authorized this visit to our center, you will be responsible for payment.

Some insurance companies provide coverage only for services that are medically necessary. If you received services determined by your insurance company to be not medically necessary, you are responsible for payment.

I have read and understand the PATIENT RESPONSIBILITY AGREEMENT regarding insurance coverage, referrals and medical necessity. I understand that I will be financially responsible for the services I receive today unless these policies have been followed.

_____ _____

Signature of Patient, Parent or Guardian Date

_____ _____

Signature of Witness Date