Arizona Endocrinology Center
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FINANCIAL RESPONSIBILITY

1. I understand that I, ______________________, am responsible for confirming my medical benefits that of my dependent with my carrier/insurance group and that I am expected to have this information at the time of my first visit.
2. I understand that Arizona Endocrinology Center cannot guarantee that the information received from my insurance company is accurate. I am fully responsible for all charges posted to my account.
3. I understand that Arizona Endocrinology Center agreement to participate as a "preferred provider" within a specific insurance plan extends to fee schedule agreements only and that I remain ultimately responsible for all services rendered to me or my dependant by Arizona Endocrinology Center.
4. I understand that in the event that Arizona Endocrinology Center is a "participating" but not "preferred" provider for services, that no agreement exists for discounted fees and I am responsible for any difference in fees charged and reimbursed by my insurance company.
5. I understand that Arizona Endocrinology Center will bill my insurance company according to all Federal rules and regulations regarding such activities and provides my insurance company with copies of all appropriate and required information and that Arizona Endocrinology Center is not responsible for lost claims.
6. I understand that Arizona Endocrinology Center will make any reasonable effort to assist me in resolving any disputed claims or payment for such claims, but that the contractual relationship for payment of such claims lies solely between myself and my insurance carrier and that I am ultimately responsible for all services provided.
7. I understand that if my plan is out-of-network or services are determined "non-covered" due to plan provisions and/or pre-existing conditions or riders on my policy, I am fully responsible for all services incurred.
8. I understand that if I elect to pay privately at my first visit, due to lack of insurance or failure to verify coverage, Arizona Endocrinology Center will NOT retroactively submit claim or change account responsibility.

ASSIGNMENT OF BENEFITS

1. I assign to Arizona Endocrinology Center the right to receive payments for all healthcare services rendered by the Company to me or my dependant.
2. I will cooperate, aid, and assist Arizona Endocrinology Center in procuring payments for healthcare services rendered to me or my dependant from any third party that is or may be liable for such services.
3. I understand and agree that I am responsible and must pay all deductibles, co-payments and amounts disputed by my insurance carrier for healthcare services rendered by Arizona Endocrinology Center to me or my dependant.
4. I understand that a cash discount for uninsured patients is ONLY applicable on payments made at the time services are rendered and does NOT apply to balances that are billed after the service date.
5. I understand that I will be charged a **fee of $25** for a returned check because of non-sufficient funds.
6. I understand that I will be charged a **fee of $25** for any scheduled appointment that I fail to appear for unless 24 hours of advance notice is provided.
7. I understand and agree that Arizona Endocrinology Center may utilize any legal means to collect payment for any healthcare services rendered to me or my dependant and I will be responsible for additional collection fees that Arizona Endocrinology Center incurs to collect such past due charges. In the event that legal action is commenced, in order to enforce the terms and conditions of this Agreement, the prevailing party shall be entitled to recovery of all attorney and/or collection fees and costs.

Signature:____ Date:_______________________

Patient, POA, Parent and/or Guardian