

Accessible Medical Care

Financial Responsibility Agreement

Please initial each line after reading.

I accept full financial responsibility for medical expenses incurred at Accessible Medical Care:

- ❖ For services provided that are not covered by my insurance plan;
- ❖ For services provided if I do not obtain a referral that may be required by my insurance plan;
- ❖ For services provided if I do not designate a Primary Care Physician (PCP) with my insurance plan and one is required;
- ❖ For service that are not paid by my insurance plan within the 45 days required by law. I understand that AMC will then forward the balance to me until remittance is received from my insurance company, upon which time I will receive a refund;
- ❖ I understand that, after services are rendered, I am requested to call my insurance company in two (2) to three (3) weeks to verify receipt and expected payment date.

I further understand that providing proof of my insurance plan(s) or explanation of benefits does not hold Accessible Medical Care responsible for verifying this information. I accept financial responsibility for any lapse on my part in providing and/or understanding my insurance benefits information at the time services are rendered.

Signature _____

Witness Signature _____

Printed Name _____

Printed Name _____