RHAD Healthcare, LLC

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PATIENT FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM

Thank you for choosing **RHAD Healthcare, LLC** 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 representative) is ultimately responsible for the payment for 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 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
- Charge for returned checks - $30.00

By my signature below, I hereby authorize assignment of financial benefits directly to RHAD Healthcare, LLC 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 Acknowledgement and Authorization

- We respect patient confidentiality and only release personal health information about you in accordance with the State and federal law. The attached notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review this policy carefully.

By my signature below, I acknowledge that I have received and read the privacy notice provided by **RHAD Healthcare,LLC**. I hereby authorize **RHAD Healthcare, LLC** and the physicians, staff, and hospitals associated with **RHAD Healthcare, LLC** to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

Print Patient Name: _____

Patient/Representative Signature: _____

Date: _____