Form 3 YCMC Patient Agreement

WHEN THIS AGREEMENT IS SIGNED BY THE PATIENT NAMED BELOW(“YOU”) IT WILL BE AN AGREEMENT BETWEEN YOU AND YOUR CONVENIENT MEDICAL CARE (YCMC).ALTHOUGH WE

ARE WILLING TO COMPLETE INSURANCE INFORMATION FORMS AND SUBMIT A CLAIM ON YOUR BEHALF, WE DO NOT ACCEPT RESPONSIBILITY-UNDER ANY CIRCUMSTANCE-FOR THE OUTCOME OF THE CLAIMS. COMPLETING INSURANCE FORMS IS A COURTESY WE EXTEND TO YOU IN AN

EFFORT TO MAXIMIZE THEIR LIKELIHOOD OF OBTAINING INSURANCE REIMBURSEMENT. BY HAVING OUR OFFICE PROCESS INSURANCE FORMS, YOU AGREE TO ACCEPT LIABILITY FOR THOSE FORMS. YOU AGREE TO PAY YOUR DEDUCTIBLE AND CO-PAYMENT (THE AMOUNT NOT

COVERED BY THE INSURANCE COMPANY) AT THE TIME SERVICES ARE RENDERED. INSURANCE PAYMENTS ORDINARILY ARE RECEIVED WITHIN 30 TO 60 DAYS FROM THE TIME OF BILLING. IF YOUR INSURANCE COMPANY HAS NOT MADE PAYMENT TO OUR OFFICE WITHIN 90 DAYS, WE MAY REQUEST YOU TO PAY THE BALANCE DUE AND THEM YOU CAN SEEK REIMBURSEMENT

FROM YOUR INSURANCE COMPANY. IF FOR SOME REASON, YOUR INSURANCE CLAIM IS

DENIED, YOU AGREE TO BE RESPONSIBLE FOR THE FULL AMOUNT OF THE BILL. YOU AGREE TO MAKE PAYMENTS IN FULL FOR ALL SERVICES RENDERED TO YOU BY YCMC. BY SIGNING BELOW, YOU GIVE YOUR CONSENT TO THE HEALTH CARE PROVIDERS AND THEIR ASSISTANTS OF YCMC TO PROVIDE MEDICAL SERVICES TO YOU, INCLUDING, BUT NOT LIMITED TO, ANY REQUIRED

EXAMINATION TO DIAGNOSE AND TREAT YOUR MEDICAL CONDITION. THIS CONSENT SHALL CONTINUE FOR AS LONG AS YOU NEED TREATMENT BY YCMC OR UNTIL YOU WITHDRAW YOUR

CONSENT IN WRITING. IF YOU HAVE AN ADVANCE DIRECTIVE OR DURABLE POWER OF ATTORNEY FOR HEALTHCARE, PLEASE GIVE A COPY TO THE RECEPTIONIST. YCMC

RECOMMENDS THAT YOU SHOULD HAVE AN ADVANCE DIRECTIVE OR DURABLE POWER OF ATTORNEY, BUT THIS IS NOT A REQUIREMENT FOR TREATMENT AT YCMC.

**Do you agree with the above policy?**

 Yes  No

**Patient's Name:**

**Patient's Social Security Number**

**Patient's Signature**

*\*If patient is unable to sign or a minor, complete Patient Signature by Surrogate from*