# Acknowledgement of Financial Responsibility and Assignment of Benefits

## I. Patient and Responsible Party Information

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| **Name of Medical Clinic:** | **THE LUXE MEDICAL CLINIC** |
| **Patient Full Name:** | _____ |
| **Date of Birth(MM/DD/YYYY):** | _____/_____/_____ |
| **Contact (Phone Number and Email):** | _____ |
| **Date of Service/Agreement:** | _____ |

## II. Financial Responsibility Agreement

I, the undersigned Responsible Party (Patient or Guarantor), hereby acknowledge and agree to the following terms regarding financial obligations for medical services provided by THE LUXE MEDICAL CLINIC:

- **1. Primary Financial Obligation:** I understand that I am ultimately responsible for all professional fees and charges incurred during the course of my/the patient's care, regardless of insurance coverage.
- **2. In-Network/Out-of-Network Fees:** I agree that all co-payments, deductibles, and co-insurance amounts are due and payable **at the time of service**. I further understand that:
    - **If the Clinic is Out-of-Network** with my insurance plan, my deductible, co-insurance, and out-of-pocket maximum may be substantially higher than in-network rates, and I may have little to no coverage.
    - It is my responsibility to confirm my out-of-network benefits *before* treatment.
- **3. Balance Billing and Non-Covered Services:** I acknowledge that the Clinic is not obligated to accept the amount paid by my out-of-network insurance as payment in full. I accept financial responsibility for:
    - All services, treatments, and procedures deemed "not medically necessary" or "not covered" by my insurance company.
    - **The entire difference ("Balance Bill")** between the total charges for the service and the amount, if any, paid by my insurance company.
- **4. Insurance Verification:** I understand that providing insurance information does not guarantee coverage, and I am responsible for verifying my benefits, authorizations, and referrals prior to receiving treatment.

## III. Assignment of Benefits (AOB)

I hereby assign to THE LUXE MEDICAL CLINIC all rights and benefits payable to me under any applicable insurance policy for services rendered.

- **Direct Payment Authorization:** I authorize and direct my insurance company to pay THE LUXE MEDICAL CLINIC directly for all medical services provided.
- **Patient Obligation for Insurer Non-Acceptance:** I understand that some insurance plans, particularly those that are **Out-of-Network**, may not honor this Assignment of Benefits and may send payment directly to me. **I agree that if my insurance company remits any payment for my care to me, I will immediately endorse and forward that payment to THE LUXE MEDICAL CLINIC**.
- **Final Responsibility:** I acknowledge that this Assignment of Benefits does not relieve me of my ultimate financial responsibility for the full amount of the clinic's charges.

## IV. Collection Policy

- **1. Missed Appointment/Late Cancellation Fee:** I acknowledge that if I fail to keep a scheduled appointment (**"No-Show"**) or cancel an appointment with less than **24 hours** notice, I may be charged a fee of **$50.00**. This fee is not covered by insurance and must be paid in full prior to my next appointment.
- **2. Delinquent Accounts:** I understand that payment for services is due upon receipt of the statement. If my account balance remains unpaid for **90 days** from the date of the first statement, the account will be considered delinquent.
- **3. Collection Costs:** I understand that if my account is sent to an external collection agency, I will be responsible for all reasonable costs of collection incurred by the clinic, which may include agency fees, legal fees, and court costs. These costs can typically add an additional **30% to 50%** to the outstanding balance.
- **4. Dishonored Checks/Returned Payments:** I acknowledge that I will be charged a fee of **$35.00** for any checks or electronic payments that are returned by my bank due to insufficient funds (NSF).

## V. Acknowledgement and Signature

By signing below, I certify that I have read and understand the contents of this form, including the financial responsibilities and the assignment of benefits. I authorize the release of any medical information necessary to process insurance claims.

SIGNATURE: _____

PATIENT/GUARDIAN'S NAME: _____

DATE: _____