HENG MEDICAL INC.

500 PASEO CAMARILLO, SUITE 100, CAMARILLO, CA 93010 TEL: (805) 484 1033 FAX: (805) 482-7213

FINANCIAL RESPONSIBILITY

Please provide a signature under each category. If you choose a paperless option, and choose to fill out the forms from your computer for email submission, adding a "forward slash" symbol before and after your typed signature denotes an accepted substitute for your written signature (example: /**First Name Last Name**/).

Financial Responsibility. You are ultimately responsible for all payment obligations.
You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier, including if the doctor is a non-contracting provider.

Patient Signature: _____

You are responsible for knowing your insurance policy.

- It is your responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized or out of network by your plan.
- If your insurance carrier does not remit timely payment on your claim, you will be responsible for full payment of the charges. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

Patient Signature: _____

Update and Verify Insurance Information at every visit.
Your card or other insurance verification must be on file for your insurance to be billed, as a courtesy we will bill your insurance. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be considered a cash-pay patient. As a cash-pay patient, our fee is expected to be paid in full at the time of service.

Patient Signature: _____

Failing to notify us of any changes related to your insurance coverage may result in unpaid claims, and you will be responsible for the full balance of the claim. Heng Medical, Inc. does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

Patient Signature: _____

I HAVE FULLY READ THE DOCUMENT, AGREE AND UNDERSTAND THE ABOVE.

FULL NAME: _____ DATE: _____

SIGNATURE: _____