Apollo Healthcare Associates LLC
Patient Financial Responsibility

Patient Name: _____ **Date of Birth: _____**

Thank you for choosing Apollo Healthcare Associates to serve as your health care provider. We are honored to participate in your health care and look forward to establishing a lasting relationship. Please read and sign this form to acknowledge your understanding of our patient financial policies.

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Initial

Release of Information. I hereby permit Apollo Healthcare Associates LLC (AHA) to release healthcare information for purposes of treatment, payment, or healthcare operations to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

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Initial

Assignment of Benefits: I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to AHA for all covered medical services and supplies provided to me during all courses of treatment and care provided by AHA and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with AHA, which will authorize and allow for direct payment to AHA of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by AHA.

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Initial

Financial Responsibility: I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to AHA and/or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify AHA of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by AHA and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

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Initial

Fees: Failure to give 24 hours cancellation notice or failure to keep your scheduled appointment may result in a charge of $25. Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a fee for canceled or missed appointments. If you must cancel an appointment, a minimum of 24 hours' notice is required. Returned checks are subject to a $25 fee.

_____	_____	_____	_____
Name of Patient	Date	Name of Authorized Representative	Date

_____	_____	_____	_____
Signature of Patient	Date	Signature of Authorized Representative	Date

Updated December 15, 2015