Patient Responsibility Form

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pat the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to ARIZONA RHEUMATOLOGY CONSULTANTS, PLC on my behalf for any services furnished to my by providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize ARIZONA RHEUMATOLOGY CONSULTANTS, PLC to release my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnoses 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.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in ARIZONA RHEUMATOLOGY CONSULTANTS, PLC. I authorize any holder of medical to other information about me to release to Medicare and its agents any information needed to determine these benefits or benefit for related services.

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Signature of Patient, Authorized Representative or Responsibility Party Date

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Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient