PRIMARY CARE, PLLC

Patient Financial Agreement

Date: _____

Patient Name: _____ D.O.B: _____

(Patient Check All Applicable)

- ☐ I agree to pay for today's Services_____/_____/_____
- ☐ I do not want my insurance charged for today's services and I agree that a claim may be sent to my insurance as a courtesy_____/____/_____
- ☐ I acknowledge that should my insurance not cover this visit that it is my responsibility to pay for services rendered by the Provider/Nurses on time of check out. ____/____/_____
- ☐ I was advised of my deductible on _____/_____/____ in the amount of $_____.____ of which $_____.____ has been met.

(Employee)

- ☐ Insurance verified on _____/_____/_____
- ☐ Patient was advised that he/she must pay for visit on _____/_____/_____
- ☐ Patient was advised of co pay _____/_____/_____
- ☐ Patient was advised of Balance for Date(s) of service(s) prior to today's visit

  ____/____/_____ ____/____/_____

  ____/____/_____ ____/____/_____

  ____/____/_____ ____/____/_____
- ☐ Patient was advised of deductible on ____/____/_____ in the amount of $_____.____
- ☐ Patient was sent to billing office for further clarification
- ☐ Other:_____

Employee Initials: _____ Date: ____/____/_____

Patient / Guardian Signature: _____

Revised 07/22/2013