Karu Medical Associates

Agreement of Financial Responsibility

Patient Name:_____ Date:_____

Thank you for choosing Karu Medical as your health care provider. We are committed to providing quality care and service to all our patients. To assist in understanding your financial responsibilities we ask that you read and sign this form.

- It is your responsibility to know your own insurance benefits, to include any co-pays, deductibles, in-network / out of network coverage and non-covered diagnostic services provided outside our facility. (lab, hospital, etc.)
- We will attempt to confirm your insurance coverage prior to your care. It is **your responsibility to provide current and accurate insurance information,** including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- You will be required to follow all registration procedures, to include updating and verifying personal information, presenting your insurance card(s), and paying any co-pays or other patient responsibility amount at each visit. Your insurance card must be on file/verified for your insurance to be billed. **If we do not have your card on file or are unable to verify your eligibility for benefits, you will be registered as a self-pay patient.** As a self-pay patient all services are to be paid in full at the time of service. If your insurance card and necessary information is provided after your visit we will send a claim to your insurance carrier and if paid in full by your insurance you will be reimbursed.
- You will be mailed a billing statement of your total cost due. You must notify us of any errors or objections within 20 days or your statement will be deemed accurate.
- Payment is due for documents needing medical information and your providers' signature **upon receipt of the documents, to include FMLA and disability paperwork, etc.**

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- I understand that I am responsible to provide all insurance identification and to know the rules of my insurance coverage
- I understand that I am financially responsible for any amount not covered by my insurance including, but not limited to, co-pays, deductibles, and non-covered services.
- I understand that if I am a self-pay patient, I am responsible for payment at the time of service unless other arrangements have been made in advance.
- I understand that I will be charged for documents needing completion at the time they are presented to the office. ($25 for completion within 7-10 business days and an additional $15 for completion within 7 business days.)

By my signature below, I acknowledge that I understand and agree to these terms:

_____ _____

Signature of Patient Today's Date

_____ _____

Printed Name of Patient Date of Birth