



Patient Name: _____ DOB: _____ Acct. # _____

Agreement of Financial Responsibility

Thank you for choosing **Central Ohio Primary Care Physicians, Inc. (COPC)** as your health care provider. COPC is committed to providing quality care and service to all of our patients. The following is a statement of COPC's financial policy, which we require that you read and agree to prior to receiving any treatment from COPC.

Payment of your bill is considered part of your treatment. Copays are required at the time of service. Self pay balances may also be due when services are rendered. COPC accepts only credit cards for payment at the time of service.

It is your responsibility to know your own insurance benefits, including:

- whether COPC is a contracted provider with your insurance company;
- your covered benefits and any exclusions in your insurance policy; and
- any pre-authorization requirements of your insurance company.

COPC will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information to COPC, including any updates or changes in your insurance coverage. Should you fail to provide this information, you will be financially responsible for the costs of the services rendered by COPC.

If COPC has a contract with your insurance company, COPC will bill your insurance company first, less any co-payment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

If COPC does not contract with your insurance company, you will be expected to pay for all services rendered. Payment may be required at the time of service but will also be expected when a statement of balance due is received. COPC will provide you with a statement that you can submit to your insurance company for reimbursement if necessary.

Proof of insurance and photo ID are required for all patients. COPC will copy your ID and insurance card into our electronic health system. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

Some insurance coverage has Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policy stated above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I acknowledge that if my insurance company denies coverage and/or payment for services provided, I will be financially responsible and will pay all such charges due and owing in full.

Signature of Patient /Responsible Party

Date

Name of Patient/Responsible Party (please print)

Relationship to Patient