advocare

_____
Care Center Name

Advocare Patient Financial Responsibility Form **Today's Date: _____**

Patient:_____ DOB:_____

I accept the financial responsibility for today's visit for the following reason(s):

_____ I do not have insurance coverage at this time, therefore I am a **SELF-PAY** patient

_____ I am unable to provide my insurance information at this time.

_____ Advocare is non-participating with my Insurance plan.

☐ Complete **'Out of Network'** Form

_____ I am requesting that my insurance not be billed, and I will be **SELF-PAY** for these service(s)

☐ Complete **'Disclosure Restrictions to Health Plans'** Form

_____ I did not bring a written referral and/or pre-authorization, which may be required by my insurance plan. I acknowledge responsibility and may be responsible for payment in full for today's visit.

_____ I did not bring my co-payment amount, which is due at the time of service. I will receive an invoice which I am required to pay.

_____ I understand that the services rendered will not be covered under my insurance benefit plan, and therefore I am responsible for full payment.

☐ Medicare Patients, Complete **'Advance Beneficiary Notice of Noncoverage (ABN)'**

_____ I

_____ Other:_____

I also understand I am responsible for any fees incurred should my account require collection action (i.e. late fees, collection agency, court or attorney costs).

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Name of Patient or Legal Guardian Date

If you are the Patient's Legal Guardian, other than parent, or if you are the Patient's Power of Attorney, a copy of the legal document granting you such power must be on file with Advocare LLC.

V6.2019