

Patient Financial Responsibility Form/Self-Pay Waiver

Thank you for choosing **IM | Health** for your medical needs. We are committed to providing you the highest quality healthcare, but we are not a collection agency.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care. **Please select ONE below:**

- ☐ **Check here** if you agree to the **self-pay rate for services rendered, at time of service.**
- I voluntarily choose to receive treatment from this provider and agree to pay in full for all services rendered. I understand that I am personally responsible for all charges incurred and that payment is due at the time of service.
 - I understand that the provider named above is not enrolled as a Medicaid provider and does not accept Medicaid as payment for services.
 - I understand that Medicaid will not pay for any services I receive from this provider. I acknowledge that I cannot submit a claim to Medicaid for reimbursement.

- ☐ **Check here** if you elect to use available medical insurance for visit coverage. You may be responsible for a copay or deductible per your insurance provider.
- We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance.
 - Copayments are due at the time of service.
 - Patients are responsible for payment of copays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- o You will NOT receive a bill. Your credit card on file will be charged, and a receipt published to your patient portal.**

WE ARE NOT A COLLECTION SERVICE.

You will be charged for any balance your insurance contract designates as your responsibility.

*Please note when choosing **either** of the above options; **A VALID CREDIT CARD ON FILE WILL BE REQUIRED PRIOR TO SERVICE.**

By my signature below, I hereby authorize assignment of financial benefits directly to **IM | Health** and any associated entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment. **I also accept the fees charged as a legal and lawful debt and agree to pay said fees, including any/all collection agency fees, if such be necessary.** I understand that **IM | Health** does not participate with any Medicaid/QMB products and that I will be responsible for any balances resulting from my care.

Patient Name

Date of Birth

Patient or Parent/Guardian Signature

Date