im | HEALTH

372 West Lancaster Ave
Wayne, PA 19087

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.
    - **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.

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Patient Name **Date of Birth**

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Patient or Parent/Guardian Signature **Date**