Patient Name: ______________________
Patient DOB:______________________
Account #: _________________________

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Lakeview Clinic as your healthcare provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. We ask that you read and sign this form to understand financial responsibility.

Insurance: Lakeview participates with most insurance plans, including Medicare. The patient (parent/guardian if minor) is responsible for knowing insurance coverage and service benefits. Please contact your insurance company with any questions you have regarding your coverage. Some services you may receive may be non-covered or not considered reasonable or necessary by your insurance plan.

The patient is responsible for providing updated policy information to Lakeview Clinic at the time of service and when policy information changes. You will be asked to provide a copy of your valid insurance and photo ID during registration/check-in.

Claims: Lakeview Clinic will submit claims on your behalf directly to your insurance carrier. Your insurance carrier may require you to submit additional information directly, and you are responsible for providing that information. The claim balance is your responsibility whether or not your insurance pays your claim.

Co-payment and Prepayment: All copayments must be paid at the time of service. Patients without active insurance will be required to pay a deposit toward services rendered, understanding that any services over the cost of that deposit will be billed to the patient.

Ancillary Services: You may receive ancillary medical services while a patient of Lakeview Clinic, such as anesthesia, interpretation of tests, laboratory services, imaging services (e.g., x-rays, MRIs), and pathology specimen examination. By signing below, you understand that some physicians may not provide services in your presence but are actively involved in diagnosis and treatment. You authorize payment directly for these services under the policy(s) or plan(s) issued to you by your insurance carrier. You may incur additional charges as a result of these ancillary services. You agree to pay all charges due for such services after benefits paid on your behalf by any third party are credited to your account.

Additional Charges: Patients may incur and are responsible for the payment of additional charges at the discretion of Lakeview Clinic, including but not limited to (i) charges for returned checks, (ii) charges for a missed appointment without 24 hours advance notice; (iii) charges for extensive phone consultations and after-hours phone calls requiring treatment, or prescriptions; (iv) charges for copying and distribution of patient medical records; (v) charges for extensive forms preparation or completion; or (vi) any costs associated with collection of patient balances, all as allowed by law.

Non-payment on Account: Patient account balances over 30 days are considered past due and will start to incur an interest charge of .5% monthly. Lakeview may require payment on past due balances in order to schedule future appointments unless the patient has already made payment arrangements with the Business Office. If there is no payment on the patient's balance after 90 days, Lakeview will send a letter regarding making payment arrangements. If no payment is made 60 days after the letter is sent, and a payment plan has not been set up with Lakeview, the account may be transferred to a collection agency.

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Printed Name: __________________________ Date: ___________________________________

Signature: _____________________________ Relationship to Patient: ___________________