Financial Responsibility Agreement

Advent Health Group, P.C.

Please initial each line after reading.

I accept full financial responsibility for medical expenses incurred at Advent Health Group,PC;

- ★ for services provided that are not covered by my insurance plan; _____
- ★ for services provided if I do not obtain a referral that may be required by my insurance plan; _____
- ★ for services provided if I do not designate a Primary Care Physician (PCP) with my insurance plan and one is required; _____
- ★ for services that are not paid by my insurance plan with the 45 days required by law. I understand that Advent Health Group will then forward the balance to me until remittance is received from my insurance company, upon which time I will receive a refund; _____
- ★ I understand that, I will be charged a $50.00 fee if I do not show up for a scheduled appointment or cancel an appointment on the same day that it is scheduled. _____

I further understand that providing proof of my insurance plan(s) or explanation of benefits does not hold Advent Health Group, responsible for verifying this information. I accept financial responsibility for any lapse on my part in providing and/or understanding my insurance benefits information at the time services are rendered.

______________________________	______________________________
Signature	Witness Signature
______________________________	______________________________
Printed Name	Printed Name
______________________________	______________________________
Primary Insurance	Plan Date
______________________________	
Date	

Advent Health Group, 5275 Lee Highway # 302, Arlington, VA 22207

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