Financial Responsibility Agreement

I,_____, understand that I am responsible for all charges incurred for treatment provided to me at Community Health Connections. I consent that the healthcare benefits from my insurance policy are paid directly to Community Health Connections, in consideration of services rendered up to the total amount of my account.

It is my responsibility to provide the correct insurance information. Any balance remaining after insurance benefits have been paid is my responsibility. I will pay that balance within 60 days unless other arrangements have been made. I also understand that in the event of default, my account will be sent to a collection agency.

Co-Pays are due at the time of services.

I authorize Community Health Connection to release any information acquired in the course of my treatment to my insurance company.

Print Name _____ DOB:_____

Signature _____ Date: _____

(Minor Patients)

Patient Name_____

DOB:_____

Parent/Legal Guardian Name_____

Parent/Legal Guardian Signature_____

Date:_____

10/2022