



# Insurance Disclosure and Financial Responsibility



All professional services rendered by Pinnacle Care Providers, LLC are charged to the patient and/or necessary insurance carrier(s). Necessary forms will be completed to expedite insurance carrier payments, with understanding the patient is ultimately responsible for all fees.

I hereby authorize the release of any medical information necessary to process insurance claims or any medical information needed for any utilization review or quality assurance activities. I hereby assign to the physician all payments for medical services rendered. I understand I am responsible for any amount not covered by insurance. I agree to pay any balance in full no later than 30 days from statement date, unless other arrangements have been made in advance. I authorize the use of this signature on all insurance submissions.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## FININCIAL POLICY AND PATIENT FINANCIAL RESPONSIBILITY

### I. Patient Responsibilities

- a. You, as the patient, are ultimately responsible for all fees. We do accept insurance assignment and will file your insurance claim for you; however, you are still responsible for all co-payments or balances as required by your specific insurance plan. You should know your plan’s policy and benefit information. You are required to bring your insurance card to each visit. If you have a co-pay we are required by contractual agreement to collect at the time of service.

### II. Insurance Benefits Verification

- a. While every effort will be made to pre-authorize and approve treatments and procedures with your insurance, it is impossible for us to know every individual’s insurance restrictions and benefit information. Most insurance companies will not guarantee payment or eligibility to us prior to submitting a claim form after your care has been completed. Please let us know if you have questions or receive information from your insurance company.

### III. No Show / Failure to cancel appointment

- a. If you are unable to keep your scheduled appointment, it is your responsibility to cancel your appointment with our office. Failure to cancel at least 24 hours in advance may result in a \$25.00 no-show fee.

I hereby acknowledge the information I have provided to Pinnacle Care Providers, LLC is correct and true to the best of my knowledge. If my insurance does not cover the costs of my medical services, or I do not have medical insurance, I agree to be financially responsible for the balance.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_