Financial Responsibility, Assignment of Benefits & Notice of Receipt of Privacy Practices

Financial Responsibility

Payment for all professional services rendered is due at the time of service. If you have health insurance, it is your responsibility to ensure we have correct and current information for insurance billing. It is also your responsibility to pay the copay, coinsurance and deductible at the time of service, as our contracts with insurance companies require us to collect these amounts. If you do not have your copay with you at the time of service, you may be asked to reschedule your appointment. For your convenience, we accept payments via cash, check, debit and credit cards.

If you are not covered by health insurance, Sterling Health Solutions offers a sliding fee discount schedule for those who qualify. However, even for the uninsured, payment for services rendered is required at the time of service. Our Sliding Fee Scale Policy is available upon request and explains the program in detail.

Assignment of Benefits & Receipt of Privacy Practices

I hereby assign all medical benefits, to include major medical benefits, to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health or medical plan, to issue payment(s) directly to Sterling Health Solutions for medical services provided to me and/or my dependents regardless of my insurance benefits, if any.

I understand that I am financially responsible for copay, coinsurance and deductible at the time of service and for any services rendered as "not covered" by my insurance.

I certify that the insurance information I have provided to Sterling Health Solutions is true and that it is my obligation to know my payor's requirements and ensure that they have been fulfilled.

I understand that my insurance(s) may not pay 100% of the amount of the medical claim for services rendered and that I may be responsible for any and all amounts not payable by my insurance(s).

I agree to notify Sterling Health Solutions of any changes in the information I have provided.

This assignment of benefits will remain in effect until revoked by me in writing to Sterling Health Solutions.

My signature below acknowledges that I have reviewed the **Notice of Privacy Practices**, been given a copy at my request, and understand my rights as a patient.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Witness Date