Patient Name: _____
Patient DOB: _____

FRANCISCAN MISSIONARIES OF OUR LADY HEALTH SYSTEM

Our Lady of the Lake Physician Group
Lourdes Physician Group
St. Francis Medical Group

PATIENT RESPONSIBILITIES

Payment Guarantee & Insurance Authorization/Assignment of Insurance Benefits

I agree to pay for all past due balances that were unpaid by my insurance company, copays, co-insurance, deductibles or non-covered charges for diagnostic procedures and medical treatment and understand that payment is due at the time of service. If I do not have medical insurance, I understand that it is my responsibility to make financial arrangements prior to services rendered. I further authorize third parties to pay directly to the Physician Group any insurance benefits due for services rendered on behalf of me or the named patient. I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to the Physician Group. I agree to notify the Physician Group of any changes in insurance, address or other information included in patient registration. I understand I am responsible for all charges not paid by my insurance company. If it becomes necessary to collect any sum due through an attorney, then, I agree to pay all reasonable costs of collection including attorney's fees, whether suit is filed or not. Additionally, I agree to pay court costs associated with such collection efforts.

I understand that I am responsible for verifying that my provider participates with my insurance plan and that I must present a copy of my card at each office visit.

I understand that if the patient is a minor, the adult accompanying the child for treatment will ultimately be responsible for payment. The Physician Group does not become involved in third party liabilities, personal injury, or custody issues to determine the responsible party for payment. We cannot accept an attorney's letter of payment guarantee.

I understand that any account that has been placed in delinquent status will be sent to an independent collection service. This balance may be subject to reporting to the credit bureau and possible termination of the doctor/patient relationship. If you are having financial difficulties that prevent you from paying your balance, please ask your patient service representative for a Financial Assistance application.

Authorized Representative

By signing this document, I give written consent to the Physician Group to act as my authorized representative in any internal or external review of an adverse claim determination under Louisiana Administrative Code title 37 Chapter 62, Medical Necessity Review Organizations, or other state or federal administrative regulation governing medical necessity review, or subsequent appeal of such determination. I understand that in the event that the service is determined not to be medically necessary, and I thereafter request the services, nothing shall prohibit the provider from charging usual and customary charges for all non-medically necessary services provided.

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Pre-Certification
Pre-certification or prior approval may be required by your health plan before certain procedures, tests, or surgeries are performed. We will assist you in the pre-certification process by contacting your insurance company on your behalf. However, it is your responsibility to confirm that you have been granted approval or certification before your appointment or you will be responsible for any charges insurance has not granted prior approval.

Termination of Physician-Patient Relationship Policy
Your physician at his/her discretion and judgment, may discontinue treatment of a patient for rude, inappropriate or egregious behavior, noncompliance with treatment recommendations, failure to obtain medically necessary referrals or further testing, failure to follow medication regimens, failure to meet financial obligations, or breakdown of the physician/patient relationship.

Other Physician Charges
Our practice is committed to providing the best treatment for our patients which may necessitate the outsourcing of some services to other professionals. When this occurs, you may receive a statement from the provider of ancillary services such as pathology, laboratory, and/or radiology interpretation services.

Forms, Letters and Copies of Medical Records
These fees will not be filed to your insurance. You will be personally charged. This includes completion of all forms, letters and copying of medical records. Copies of medical records will be charged to the requesting party by the copying company.

By signing below, I acknowledge that I have read this form, and fully understand and accept its terms and conditions. I have had a chance to ask any questions that I might have.

Patient Name (print): _____

Patient Signature: _____

Date: _____ **Time:** _____

Legal Guardian Name (print): _____

Legal Guardian Signature: _____

Date: _____ **Time:** _____