MICHAEL N. BROWN, MD

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PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Thank you for choosing the offices of Michael N Brown, MD. We are honored by your choice and are committed to providing you with the highest quality of healthcare services. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

I, ______________________________________the patient (or patient's guardian, if a minor) is responsible for any and all fees for all treatment /care rendered at the time of service. By signing this waiver, I acknowledge that I am aware that this office does **not** provide insurance billing services of any kind to include personal injury cases, work comp carriers and attorneys and that all fees are due and payable on the date that the service is provided.

For your convenience, we accept cash, check, and most major credit cards with the exception of American Express at our office.

For Insurance Patients not covered by Medicare Part B:
This office is happy to assist you by providing you with a "superbill" with all necessary codes for services rendered. This superbill will show that payment was made in full by you and that the insurance company is to reimburse you directly for any/all potentially covered services. This superbill is provided to you only when fees are paid IN FULL and as a courtesy to you. This superbill in no way implies that this office will be billing your insurance carrier / attorney / third-party payer for you.

I acknowledge that I am aware that Michael N. Brown, MD is **not** listed on any medical provider networks or lists for any insurance agency(ies) including Medicare / MediCal / Medicaid. Any potential reimbursement provided to me by my health insurance carrier is determined by my particular policy and is on an out-of-network provider basis. I understand that it is my responsibility to be aware of my coverage limits.

Workman's Compensation:
I further acknowledge that the treatment that I am requesting is **not** in response to a work related injury, which would require that I immediately report the injury to my employer and follow all necessary state worker's comp protolcols. I understand that Michael N. Brown, MD is **not** on any of the MPN (Medical Provider Network) lists for worker's compensation.

Patients may also incur and are responsible for the payment of additional charges. These charges may include (but are not limited to):

- Charge for returned checks or cancelled credit card payments.
- Charge for missed appointments without 48 hours advance notice
- Charge for phone consultations and/or after-hours phone calls requiring review of records, diagnosis, treatment recommendation and/or prescriptions.
- Charge for the copying and distribution of patient medical records.
- Charge for extensive forms completion.
- Any costs associated with collection of patient balances.

Patient Authorizations:
By my signature below, I hereby authorize this office to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care.

By my signature below, I authorize this office to communication by mail, answering machine message, voicemail message and/or email information regarding my care.

I authorize my medical information to be disclosed to:________________________________relationship to self_________________________.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Acknowledgement which will expire 1 year from the date signed:

Today's Date: ______________________________

Patient Name (Printed): ____

Patient/Guardian Signature: ____