HT Family Care Associates, LLC
Hometown Concierge Health
Hometown Family Health

Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Hometown Concierge Health appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Hometown Concierge Health, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Hometown Concierge Health, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____Date _____

Consent for Treatment and Authorization to Release Information

I hereby authorize Hometown Concierge Health, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Hometown Concierge Health, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature _____Date _____

Self-Pay

I do not have health insurance and will be responsible for services rendered here at The Practice Name. I agree to pay The Practice Name, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ Date _____