STATEMENT OF FINANCIAL RESPONSIBILITY

Welcome to the office of Dr. Amina Ahmed. We are pleased that you have chosen our office for your health care needs. This policy is to outline your financial obligations whether or not you have insurance. Please ask questions if you do not understand this policy.

<u>Insurance</u>

If you have insurance, we will verify your insurance coverage before agreeing to file your insurance. It is, however, <u>your responsibility</u> to know about your insurance and what services are covered. This includes outpatient services such as lab work, imaging services, and hospitals.

It is the policy of this office to have every person responsible for paying his or her co-payment, any unmet deductible, or the percentage of the bill per insurance carrier. This payment is due to know about your insurance and what services are covered. This includes outpatient services such as lab work, imaging services, and hospitals.

It is the policy of this office to have every person responsible for paying his or her co-payment, any unmet deductible, or the percentage of the bill per insurance carrier. This payment is due <u>at the time of service</u>. We gladly accept checks or cash.

<u>No insurance</u>

If you do not have insurance, payment in <u>full</u> is required <u>at the time of service</u>. We gladly accept checks or cash.

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Please read and sign in the appropriate space below.

<u>Insurance</u>

I understand that even though I have insurance coverage, I am still responsible for my account. I agree to pay in full what my insurance company does not cover and any co-payments, deductibles, and/or co-insurance.

_____

Name of responsible party (please print)

_____   _____

Signature of responsible party   Date

<u>No insurance</u>

I understand that even though I do not have insurance coverage, I am still responsible for my account. I agree to pay in full the charges of this office.

_____

Name of responsible party (please print)

_____   _____

Signature of responsible party   Date