

NORTH COAST FAMILY MEDICAL GROUP, INC.

MEMBER ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Date: _____

Patient Name (please print): _____

Date of Birth: _____ Member ID or Soc. Sec. no. _____

Insurance Company _____ HMO PPO

I, the patient or legal guardian of patient, understand that it is my responsibility to provide a copy of my health insurance card to North Coast Family Medical Group to facilitate claim processing. If I am unable to provide this information, I understand that all services will be my financial responsibility until such information is provided.

If an insurance card is given, I acknowledge that if the patient is determined as “not eligible” under my insurance membership provisions and/or any specific procedures are not covered, financial responsibility for services rendered is mine.

My primary care physician is _____

I agree to pay in full for all services rendered within 30 days of receiving a bill from the above noted physician or any healthcare provider from North Coast Family Medical Group if insurance information is not provided or covered under my plan.

Signature of patient or legal guardian

Date