Marlton Neurology
Marlton Family Medicine
Chronic Pain Specialists

562-B Lippincott Dr. Marlton, NJ 08053
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Patient Financial Responsibility Form

1. **Patient Responsibility:**
   I understand that I am financially responsible for all charges related to my care, including but not limited to co-payments, deductibles, co-insurance, and non-covered services.

2. **Insurance Verification:**
   I acknowledge that it is my responsibility to verify that my insurance plan provides coverage for services rendered by the practice(s). I understand that any coverage determination made by the Doctor's office is not a guarantee of payment.

3. **Referral:**
   If my insurance plan requires a referral, it is my responsibility to obtain the referral from my primary care practice before I receive services at the Doctor's office. I understand that in the absence of a referral, my insurance may deny the payment of services and I shall be responsible for paying full amount of the claim.

4. **Billing and Payment:**
   I agree to pay any amounts not covered by my insurance, including co-pays and deductibles, at the time of service unless other arrangements have been made. I also agree to respond promptly to any billing statements and to make payments as required.

5. **Contacting the office by phone or email:**
   I understand that when I contact the doctor's office by phone and email, some or all of those encounters may be billed to my insurance. As determined by my insurance, I will be financially responsible for any charges payable by me.

6. **Collections:**
   If my account becomes delinquent and is sent to a collection agency, I understand that I am responsible for all collection costs and legal fees incurred in the collection of my debt.

I acknowledge that I have read and understood the financial policies of the practice(s). I consent to the financial terms outlined above.

Patient/Legal Guardian Signature

Date

Patient/Legal Guardian Name