FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: __________________________
Medicare Number: ________________________
Date: ________________________________

I, the undersigned, understand that I am seeking medical services from [Provider Name/Clinic Name]. By signing this document, I acknowledge and agree to the following terms regarding my Medicare coverage:

1. Deductibles and Co-insurance: I understand that I am responsible for paying any annual deductibles and the 20% co-insurance amount required by Medicare for covered services.

2. Non-Covered Services: I understand that Medicare does not cover all healthcare costs. I agree to be financially responsible for any services, supplies, or procedures that are deemed "non-covered" or "not medically necessary" by Medicare.

3. Advanced Beneficiary Notice (ABN): If my provider believes that Medicare is likely to deny payment for a specific service, I will be provided with an ABN. By signing the ABN, I accept responsibility for payment if Medicare denies the claim.

4. Supplemental Insurance: If I have secondary or supplemental insurance (Medigap), I authorize [Provider Name] to bill that insurer on my behalf. However, I remain responsible for any balance not paid by the supplemental insurance.

5. Assignment of Benefits: I authorize payment of medical benefits directly to [Provider Name] for services rendered. I also authorize the release of any medical information necessary to process my insurance claims.

6. Payment Policy: Payment for co-pays or non-covered services is expected at the time of service unless prior arrangements have been made.

I have read and understood the terms of this agreement.

____
Patient/Guarantor Signature

____
Date