Quality Life Group
Financial Responsibility Agreement

Please sign below to indicate your agreement to the following:

As a courtesy to you, Quality Life Group will bill your insurance carrier for services rendered. Be aware that insurance coverage is a contract between the subscriber and the insurance company. Therefore, insurance payments for services may be sent directly to you or the subscriber, especially if you have **Out of Network** benefits. If you receive an Explanation of Benefits and a check for your claim, please remit payment to Quality Life Group for the payment amount received from your insurance company and include a copy of the explanation of Benefits or bring the check into our office. You, the patient/guarantor will be held accountable for any insurance payments sent directly to you and not paid to Quality Life Group for services rendered.

Quality Life Group has instituted a "no show" policy that requires you to notify the office 24 hours prior to cancelling or changing your appointment. A cancellation less than 24 hours will be considered a "no show" and will be subject to an $80.00 charge. Specific emergencies will be considered.

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits.

I understand and agree that it is my responsibility and not the responsibility of the provider to know if my insurance will pay for any services I receive.

I understand and agree it is my responsibility to know if my insurance plan has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit or any other type of benefit limitation for the services I receive.

I understand and agree that my co-payment is due at the time of service. No exceptions. I may pay with cash, check, and most major credit cards.

I understand and agree that Quality Life Group requires my credit card information and that they will keep it on file in a secure electronic record to hold my appointments. Quality Life Group will ask me for this information when I schedule my first appointment.

I understand and agree that Quality Life Group is authorized to bill my credit card on file for services that are not covered by insurance including no show fees. It is my responsibility to update information with the office to avoid additional out of pocket charges.

Client Signature/ Date _____/_____

Print client name/Date _____/_____

Guarantor Signature/ Date _____/_____

Print Guarantor Name/Date _____/_____

Staff that input credit card information Signature/ Date

_____/_____