OVIEDO CHILDREN'S HEALTH CENTER

Patient Financial Responsibility

Patient Name: _____ DOB: _____/_____/_____

- Our staff will ask you for payment for any past due balances as well as your portion of the deductible for today's service.
- Payment is expected at the time of service. This includes all co-payments, co-insurances and deductibles.
- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- In the event that my health plan determines a service(s) to be "not payable" I will be responsible for the complete charge and agree to pay the costs of all services provided.
- In the event that my health plan determines an immunization(s) to be "not payable" I will be responsible for the complete charge and agree to pay the costs of all immunization(s) provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

By Signing below, I acknowledge I understand the Patient Financial Responsibility outlined above.

Date: _____/_____/_____

Printed Name of Responsible Party: _____

Signature of Responsible Party: _____

Relationship to Patient: _____