

Patient Financial Responsibility Form

Introduction

This Patient Financial Responsibility Form ("**Form**") is entered into by the Patient ("**Patient**") and the Aldiwani Medical Group ("**Provider**"), collectively referred to as the "Parties", and is governed by the laws of the State of California. This Form outlines the financial responsibilities of the Patient in relation to the healthcare services provided by the Provider. By signing this Form, the Patient acknowledges their understanding and agreement to the terms and conditions set forth herein.

Patient Information

This Form requires the following information from the Patient:

- Full Legal Name: _____
- Date of Birth: _____
- Address (including city, state, and ZIP code):

- Phone Number: _____
- Email Address (if applicable): _____
- Emergency Contact Information (including name, relationship to the patient, and contact number):

The Patient agrees to provide accurate and up-to-date information and to notify the Provider of any changes to this information in a timely manner.

Financial Responsibility Acknowledgment

This Financial Responsibility Acknowledgment ("**Acknowledgment**") is made by the undersigned Patient the Provider located in the State of California. By signing this Acknowledgment, the Patient agrees to be financially responsible for all charges for medical care, treatment, and services provided by the Provider.

The Patient acknowledges that it is their responsibility to:

The Patient's failure to comply with this Acknowledgment may result in the Provider taking necessary actions to secure payment, including but not limited to, referral to a collection agency.

Consent to Release Information

By signing this Form, the Patient hereby authorizes the Provider to disclose health information pertaining to the Patient's treatment, payment, and healthcare operations as necessary to carry out treatment, payment, and healthcare operations. This authorization includes the release of medical information to other medical providers involved in the Patient's care, and, when applicable, governmental health agencies pursuant to the requirements of federal and state laws.

The Patient understands that this consent to release information is voluntary and that the Patient may revoke this authorization at any time by providing written notice to the Provider. However, the Patient acknowledges that any action taken in reliance on this authorization prior to the receipt of such revocation shall not be affected.

This consent shall remain in effect until revoked by the Patient in writing.

Payment Policy

This Payment Policy outlines the financial responsibilities of the Patient in relation to the services provided by the Provider. By signing this document, the Patient agrees to the following terms:

1. The Patient is responsible for the payment of all charges for medical services received.
2. Payments are due at the time of service unless other arrangements have been made in advance with the Provider's billing department. Failure to make timely payments may result in additional charges or the initiation of collection procedures.
3. The Patient is encouraged to contact the Provider's billing department for any questions regarding charges or payment arrangements.
4. It is the Patient's responsibility to ensure that all necessary referrals and pre-authorizations are obtained prior to receiving services.

Cancellation and No-Show Policy

In recognition of the value of both the Patient's and the Provider's time, the following policy applies to all scheduled appointments. This policy is in place to ensure that the Provider can provide timely and efficient care to all patients.

- Patients are required to notify the Provider at least 24 hours in advance if they need to cancel or reschedule their appointment. Failure to do so may result in a cancellation fee, as detailed below.
- A cancellation fee of \$50 will be charged to the Patient's account for any missed appointments or cancellations made less than 24 hours before the scheduled appointment time.
- In cases of emergency or sudden illness, exceptions to this policy may be made at the discretion of the Provider. Documentation may be required for the fee to be waived.
- Repeated no-shows or late cancellations may result in the Patient being discharged from the Provider's practice.

This policy is effective as of the date of the Patient's signature on this Form and is subject to change with prior notice to the Patient.

Outstanding Balance Policy

This Outstanding Balance Policy ("**Policy**") applies to all charges for medical services rendered by the Provider to the Patient. The Patient acknowledges that it is their responsibility to ensure that all charges for medical services received are paid in full.

Outstanding balances must be paid within 30 days from the date of the statement. Failure to pay the outstanding balance within this period may result in additional charges, including but not limited to, interest at the legal rate allowed by California law, collection fees, and attorney's fees, if necessary, to recover the amount owed.

The Provider reserves the right to refuse further treatment to the Patient if there are any outstanding balances on the Patient's account. This Policy is subject to change by the Provider without prior notice to the Patient.

Privacy Practices Acknowledgment

By signing this document, the Patient acknowledges that they have received, read, and understood the Notice of Privacy Practices provided by the Provider. The Patient understands that this Notice describes how medical information about them may be used and disclosed and how they can get access to this information. The Patient agrees to the use and disclosure of their health information by the Provider for the purposes of treatment, payment, and healthcare operations, as outlined in the Notice of Privacy Practices.

The Patient further acknowledges that they have been given the opportunity to ask questions and seek clarification regarding the Notice of Privacy Practices and that any questions they had were answered to their satisfaction. The Patient understands that the Notice of Privacy Practices may be amended from time to time, and they agree to review any such amendments within a reasonable time frame. The Patient agrees to abide by the terms of the Notice of Privacy Practices as it may be amended from time to time.

Amendment

This Patient Financial Responsibility Form may be amended only by a written agreement, duly executed by both the Patient and the Provider. Any amendments made to this form must comply with the laws and regulations of the State of California. This includes, but is not limited to, ensuring that any changes to financial responsibility, payment terms, or dispute resolution processes are clearly communicated and agreed upon by both parties.

Governing Law

This Patient Financial Responsibility Form shall be governed by and construed in accordance with the laws of the State of California, without giving effect to any choice or conflict of law provisions or rules. Any legal suit, action, or proceeding arising out of or related to this Form or the transactions contemplated hereby shall be instituted exclusively in the federal courts of the United States or the courts of the State of California in each case located in the city and county where the Provider's facility is located. The Patient and the Provider hereby waive any and all objections to the exercise of jurisdiction over them by such courts and to venue in such courts.

By signing below, the Patient acknowledges that they have read, understood, and agree to the terms and conditions outlined in this Patient Financial Responsibility Form. The Patient further confirms that they have had the opportunity to ask questions regarding this Form and that those questions have been answered to their satisfaction.

Patient Signature: _____

Printed Name: _____

Date: _____