

# FINANCIAL RESPONSIBILITY CONSENT

San Antonio NP Associates  
Primary Care Services

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**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I understand and agree that **San Antonio NP Associates bills my insurance as a courtesy only.** Insurance verification is not a guarantee of payment. I am financially responsible for all charges not paid by my insurance, including but not limited to copayments, deductibles, coinsurance, denied claims, non-covered services, and services deemed not medically necessary by my insurance plan. Any balance remaining after insurance processing is my responsibility and is due upon receipt of a statement.

I understand that my insurance benefits are a contract between me and my insurance carrier. I authorize payment of medical benefits directly to San Antonio NP Associates and authorize the release of medical information necessary for treatment, payment, and healthcare operations.

Copayments, deductibles, and coinsurance are due at the time services are rendered unless prior arrangements are made. Returned checks, declined credit or debit card payments, or reversed transactions may be subject to an additional processing or returned-payment fee as permitted by law.

I understand that **self-pay (uninsured) patients are required to pay the posted self-pay rates at the time of service.** I also understand that certain services, including administrative services and forms (such as FMLA, short-term disability forms, employer letters, or other provider-completed paperwork), are subject to additional fees and may require payment prior to completion.

**PLEASE KEEP YOUR SCHEDULED APPOINTMENT. FAILURE TO SHOW UP TO YOUR APPOINTMENT MAY RESULT IN A \$25 NO-SHOW FEE.** Appointments cancelled with less than 24 hours' notice may be considered a no-show.

I understand that the practice accepts **Cash, Visa, MasterCard, and Discover** only. I understand that the practice does **not** bill third-party claims, including but not limited to automobile accident, personal injury, or attorney lien claims. I understand that failure to pay outstanding balances may result in collections and that the practice reserves the right to refuse non-emergency services, as permitted by law.

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I acknowledge that I have read, understand, and agree to this Financial Responsibility and Assignment of Benefits policy.

**Patient Signature:** \_\_\_\_\_ **Printed Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_