Community Health Connections
We take great care of you!

Financial Responsibility Agreement

I,______________________________, understand that I am responsible for all charges incurred for treatment provided to me at Community Health Connections. I consent that the healthcare benefits from my insurance policy are paid directly to Community Health Connections, in consideration of services rendered up to the total amount of my account.

It is my responsibility to provide the correct insurance information. Any balance remaining after insurance benefits have been paid is my responsibility. I will pay that balance within 60 days unless other arrangements have been made. I also understand that in the event of default, my account will be sent to a collection agency.

Co-Pays are due at the time of services.

I authorize Community Health Connection to release any information acquired in the course of my treatment to my insurance company.

Print Name ____ DOB:__________________________

Signature ____ Date: _________________________

(Minor Patients)

Patient Name____

DOB:______________________________

Parent/Legal Guardian Name____

Parent/Legal Guardian Signature____

Date:____

2/2019