Payment Responsibility Agreement Form

Client Name _____

Parent/Guardian responsible for payments _____

Address _____

City _____ State ____ Zip Code_____

Home Phone _____ Cell phone _____

Work Phone _____ Email_____

Client's DOB _____ Parent/Guardian DOB _____

*********Please provide a copy of your insurance card (front and back)*********

Name of Subscriber (person who holds insurance) _____

Client's relationship to subscriber _____

Subscriber insurance # (if different from client) _____

Please read the following and sign:

I understand that I am responsible for all fees regardless of insurance coverage and will pay my copay, or what I owe, at the time of service before I leave the appointment. My provider is a participating provider within the CareFirst BCBS Network (PPO, HMO, and Federal Government) and will submit claims on my behalf. If I have an out of network insurance plan, I will pay for services when rendered unless other arrangements are made in advance. I will be provided with the necessary information to help expedite my insurance carrier's reimbursement.

Client/Parent Signature _____Date_____

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