Lindner Center of HOPE
Professional Associates

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ DOB: _____ MR#: _____

Financially Responsible Party Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (s) _____

FINANCIAL RESPONSIBILITY AGREEMENT FOR SERVICES:

Lindner Center of Hope Professional Associates (LCOHPA) appreciates the confidence you have shown in choosing us to provide health care services to you or a patient for whom you have responsibility. Our patient and family-centered treatment philosophy requires that we openly communicate our policies and expectations about payment for our services before treatment is initiated. Please take a moment to familiarize yourself with these policies.

I acknowledge that the patient has signed the required release forms requesting that all billing statements are to be sent to the person named as financially responsible below. I agree that I am financially responsible for all charges associated with health care services provided by LCOHPA for the patient named above. I understand that payment for services is due at the time services are rendered unless special arrangements are made in advance.

I further understand that I have the right to revoke this responsibility upon written notification and signature of revocation.

THE UNDERSIGNED HAS READ AND UNDERSTANDS THE ABOVE.

Printed Name of Financially Responsible Party: _____

Relationship to Patient: _____

Signature of Financially Responsible Party: _____ Date: _____ Time: _____

LCOHPA Witness Signature: _____ Date: _____ Time: _____

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LCOHPA STAFF ONLY:

Date of receipt of signed Release of Information by patient _____

(Please note that the signed Release of Information is only good for 6 months.)

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I revoke my financial responsibility for this account:

Revocation Date: _____ Time: _____

Signature of Financially Responsible Party _____