Lindner Center of HOPE | UC Health

FINANCIAL RESPONSIBILITY AGREEMENT
SELF PAY SERVICES-DIETITIAN

Patient Name: ______________________ **MR#** ______________ **Date:** __________

Financially Responsible Party: ______________________
(if other than Patient)

Address: ______________ **City:** ______________ **State:** ______ **Zip:** ________

Phone Number: ______________________

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT FOR SERVICES NOT COVERED BY INSURANCE:
Lindner Center of HOPE (LCOH) 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 I am financially responsible for all charges associated with health care services provided by LCOH to me (or the patient named below) not covered by insurance. I understand that payment for services is due at the time services are rendered unless special arrangements are made in advance.

I understand that the dietitian services are self-pay and are as follows:

- Dietitian initial visit 60-minutes. $125
- Dietitian initial visit 90-minutes. $160

- Dietitian follow-up 60-minutes. $70
- Dietitian follow-up 45-minutes. $55
- Dietitian follow-up 30-minutes. $35

THE UNDERSIGNED HAS READ AND UNDERSTANDS THE ABOVE.
I am the patient or am legally authorized to sign this document. I have read and understand this Consent for Self-Pay Services.

______________________ ______________
Signature of Patient or Legal Guardian Date

____
Printed Name of Patient or Legal Guardian

____
Relationship of Legal Guardian to Patient

______________________ ______________
Signature of Financially Responsible Party Date

______________________ ______________
LCOH Witness Signature Witness Date/Time