Lindner Center of HOPE
Professional Associates

**FINANCIAL RESPONSIBILITY AGREEMENT**
**SELF PAY SERVICES- Dietician**

**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 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 I am financially responsible for all charges associated with health care services provided by LCOHPA 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 dietician services are self-pay and are as follows:

- ☐ LCHRDINIT Dietician Initial visit $135
- ☐ LCHRDFU60 Dietician follow up 60 minutes $122
- ☐ LCHRDFU30 Dietician follow up 30 minutes $61

**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.**

**Date**

_____ _____
Signature of Patient or Legal Guardian

_____ _____
Printed Name of Patient or Legal Guardian

_____ _____
Relationship of Legal Guardian to Patient

_____ _____
Signature of Financially Responsible Party

_____ _____
LCOHPA Witness Signature Witness Date/Time