

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 dietitian services are self-pay and are as follows:

- Dietitian initial visit 60-minutes. \$150
- Dietitian initial visit 90-minutes. \$200

- Dietitian follow-up 60-minutes. \$135
- Dietitian follow-up 45-minutes. \$100
- Dietitian follow-up 30-minutes. \$ 68

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

