LANGER FAMILY MEDICINE, P.A.
1806 Short Branch Drive, Suite 101
Trinity, FL 34655-4426

Agreement of Financial Responsibility

Thank you for choosing Langer Family Medicine as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company. Our staff cannot guarantee your eligibility or coverage.

- It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company. We will attempt to confirm your insurance coverage prior to your treatment.

- Not all services are covered by insurance; rules and limits vary by plan. In the event your insurance plan determines a service to not be covered, you will be responsible for the charge.

- Some insurance companies have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

- Please understand that payment of your bill is considered part of your treatment. Any fees (co-payments, deductibles, and outstanding balances) are due at time of service. For your convenience we accept cash and checks, Visa, MasterCard, American Express and Discover credit/debit cards.

I have read the policies above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Name of Patient/Responsible Party (please print) Relationship to Patient