

Agreement of Financial Responsibility

Patient: _____

Date of Service: _____

The following items have been discussed with me:

- _____ 1. I acknowledge that I have not supplied the clinic verifiable third party insurance coverage (including auto, workers compensation, commercial, Medicare or Medicaid).
- _____ 2. I have been asked to make a deposit of \$50.00 towards my treatment/services.
- _____ 3. I understand if I have no insurance coverage I will be given a discount of 20% off of total charges if full payment is made today.
- _____ 4. I understand that if I do not provide verifiable third party insurance, establish an acceptable payment arrangement, or pay my balance in full; my account will be referred to a National Collection Agency within 21 days.

Any questions regarding this bill should be made to the clinic office staff
Heart Care Centers of Florida Monday-Thursday 8:00 am - 5:00pm and Friday
from 8:00 am – 1:00pm

Patient / Guarantor

Date

Witness

Date