SOUTHERN CALIFORNIA HEART SPECIALISTS

"Comprehensive care for the heart...from the heart"

Patient Name: _____Date of Birth: _____

**Statement of Patient Financial Responsibility**

SCHS appreciates the confidence you have shown, in choosing us to provide for your health care needs. The services you have elected to participate in, implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier(s) on your behalf. However, you are ultimately responsible for payment in full of your bill after your insurance carrier pays their portion.

Many insurance companies have additional stipulations that may affect your coverage. It is your responsibility to know your coverage and benefits. You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your balance in full.

I understand that I am responsible for co-payments and deductible/co-insurance as dictated by my insurance carrier.

_____ _____

**(Signature of patient OR parent/guardian if under the age of 18)** **(Date)**

_____

**(Print Name)**