# INTEGRATED HEALTH ASSOCIATES

## STATEMENT OF FINANCAIL RESPONSIBILITY

**Please check ONE**:

- I have healthcare coverage through a ***private insurance carrier***, and understand that I will be treated as a **self-pay** patient and will remit payment at the time services are provided to me.

- My primary insurer is ***Medicare or Medicaid***. I understand that Integrated Health Associates will bill Medicare / Medicaid for covered services, and that this processing **does not guarantee payment**. I understand that I am responsible for all amounts not covered by Medicare / Medicaid, including applicable exams, deductibles, and treatment(s).

- My treatment is related to a ***Worker's Compensation*** injury or occupational condition. I understand that payment may be **subject to authorization, claim acceptance, medical necessity requirements, applicable fee schedules and other workers compensation rules**. I agree to provide accurate Worker's Compensation information, including the employer, carrier, claim number, date of injury and adjuster information.

- I have been referred by an attorney for evaluation and treatment related to a ***personal injury claim***. I understand that the settlement or recovery on my behalf **may not be sufficient** to pay all medical expenses, medical liens, health insurance claims, medical bills, or other healthcare-related expenses arising from my personal injury claim. I acknowledge and agree that I am personally responsible for any medical expenses or related charges that remain unpaid after the settlement or resolution of my claim, regardless of the amount of the settlement or recovery received.

*** I understand that it is my responsibility to notify Integrated Health Associates of any changes to my health insurance coverage or Worker's Compensation claim status, address, telephone number or other information that may affect billing.

*** By signing below, I confirm that I have read and understand this Statement of Financial Responsibility.

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Signature Date