Henry Ford Health System
Patient Financial Responsibility Agreement

Thank you for choosing Henry Ford Health System for your health care needs.

You are receiving this agreement for one of two reasons:

- You do NOT have an approved **referral** from the Primary Care Provider assigned to you by your health insurance plan
- Your health insurance plan has NOT approved an **authorization**

This means you will be responsible for the cost of your care today.

It is best for you to know what your health insurance plan will pay for and what you may have to pay. Please contact your health insurance plan for more information by calling the phone number on your health insurance card.

We ask that you read and sign below to show that you understand your role as an informed patient and what you are being asked to pay.

I understand my role to:

- **Keep Up with My Health Insurance Plan:** It is my job to make sure my health insurance plan is active before scheduling any appointments at Henry Ford Health System. It is also my job to let staff know about any changes to my health insurance plan.
- **Get Care from an Approved Provider:** I have to check with my health insurance plan to make sure the provider I want to see is approved.
- **Referrals and Authorizations:** My primary care provider and health insurance plan have not approved my visit for today.
- **Know What I Have to Pay:** I must pay for my visit before I can see the provider. A self pay deposit is due before each visit and 100% of estimated charges is due before surgeries, procedures and testing. I also understand that I will receive a bill with any unpaid amounts that I must pay in full by the due d ate.
- **Paying at the Time of Visit:** If I am unable to pay for my non-emergency care, I will not be seen today.
- **Debt Collection:** Any unpaid balance must be paid by the date on my billing statement or my bill will be turned over to a debt collector. I may not schedule any other non-emergency services until the debt is paid.
- **Emergency Care:** I understand that I can seek emergency medical care at any emergency room whether I am able to pay or not.

Patient Name: _____ Date: _____

Patient/Legal Representative Signature: _____