HENRY FORD HEALTH®

Patient Financial Responsibility Agreement

Place patient label here or fill out information below:

Patient Name: ____________________________

Date of Birth: ___________________

MRN: ___________________________

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

We believe you will be responsible for the total cost of your care today. This could be for one of the following reasons:

- You do not have an approved **insurance referral** from the Primary Care Doctor assigned to you by your health insurance plan.
- Your health insurance plan has not approved an **authorization** for your care.
- The service, drug, or device is not covered by your health insurance plan.
- Henry Ford Health System or today's provider does not participate in your health insurance plan.

It is important for you to know what your health insurance plan will pay for and what you may have to pay. Please call your health insurance plan for more information at the phone number on your health insurance card.

To get a self-pay price estimate for your cost of care, please contact the **Henry Ford Health Pricing Department** at:

- **(888) 455-2678,** or
- Email **pricing@hfhs.org**
- Pricing information is also on the webpage **henryford.com/visitors/billing/cost-of-care**

By signing below, I understand that I am financially responsible for services given to me if they are not covered by my insurance, as described above.

- A self-pay deposit is due before each visit and 100% of estimated charges is due before surgeries, procedures, and testing. I understand that I will get a bill for any unpaid balance, and it must be paid in full by the date on the bill.
- If I am not able to pay for my non-emergency care, I may not be seen today.
- 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: ____