SAN JUAN BASIN
public health

Clinic: Durango Pagosa Springs

Patient Financial Responsibility Agreement

Patient Name: _____DOB:_____

Thank you for choosing San Juan Basin Public Health as your healthcare provider. We are committed to providing you with the highest quality care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of services received at SJBPH.
- The patient understands and agrees to be financially responsible for any and all charges for services not paid by insurance.
- The patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated.
- The patient is responsible for the payment of copays, coinsurance, deductibles, and any procedures or treatment not covered by their insurance plan.
- The patient agrees that payment is due at the time of service. We accept cash, check, or major credit cards.(Visa, MasterCard, Discover)
- The patient is responsible for knowing if the provider is a contracted in-network provider recognized by their insurance company or plan. If the provider is not recognized by their insurance company or plan, it may result in claims being denied or higher out of pocket expenses to the patient. The patient understands this and agrees to be financially responsible and make full payment.
- The patient may incur and is responsible for the payment of additional charges at the discretion of SJBPH. These charges my include (but are not limited to):
    - Charge for returned checks;
    - Any cost associated with the collection of patient balances.

By my signature below, I authorize SJBPH personnel to communicate by mail, messaging, and/or email according to the information I have provided in my patient registration information.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____ _____
Signature of Patient or Guardian: Date:

_____ _____
Staff Signature: Date: