Patient Name: _____
Date: _____
DOB: _____
MRN: _____

The Polyclinic
a Washington professional services corporation

NOTIFICATION OF LIABILITY OR FINANCIAL RESPONSIBILITY

This form will be retained in your medical record.

I authorize the treatment for myself or the above individual. I authorize the physician and The Polyclinic to release any information required to process my insurance claims. I understand that my medical record may contain information regarding HIV/AIDS, substance abuse, mental health, sexually transmitted diseases, sickle cell anemia, or other sensitive information. I also authorize my insurance to directly pay The Polyclinic. A copy of this agreement may be substituted for and be legally binding as the original agreement.

I understand that regardless of insurance coverage, I am ultimately responsible for all fees for services rendered to the above named patient. I agree to pay all bills within 30 days of receipt of statement, unless other arrangements are made. I understand that payment is due and payable to The Polyclinic at its office in Seattle, Washington.

By my signature below, I acknowledge that I understand my financial responsibility to The Polyclinic.

_____

Signature of patient ***OR*** personal representative and relationship to patient