Ferris State University

Birkam Health Center

Patient Financial Responsibility

- I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service, visit or procedure, routine examination, and diagnostic or screening laboratory tests.

- I understand that it is my responsibility to supply the Birkam Health Center with a copy of the front and back of all active health insurance cards along with the subscriber's full name and date of birth. I understand that without all the necessary information, the Birkam Health Center cannot bill correctly or in a timely manner. I agree that I am financially responsible for the balance in full, if payment is denied for coordination of benefits or timely filing because of my omission.

- I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

- I authorize release of any medical or other information necessary to process the claim.

- I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

- I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

- I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

- I understand that if I have Blue Care Network or HAP insurance, I am responsible to obtain a global referral or prior authorization. I agree that if I fail to obtain the global referral or prior authorization for the date of service, I am financially responsible for all services rendered.

- I understand that it is my responsibility to verify if the provider I meet with participates with my insurance or if they are out of network. If I choose to meet with a provider that is outside of my network, I agree that I am financially responsible for the balance in full.

- I understand that some services may have a limit on the number of times they can be billed annually or biannually (examples: STI testing, TB Test/Read/Titer). I agree that I am financially responsible if my insurance company does not pay for those services.

- I understand that testing for sexually transmitted infections may not be a covered benefit of my insurance plan and I will be financially responsible for all services rendered.

- I understand and agree that if I fail to pay my account bill or any monies due in owing the Birkam Health Center by the scheduled due date, and fail to make acceptable payment arrangements to bring my account current, Ferris State University may refer my delinquent account to a third-party collection agency. I further understand and agree that my delinquent account will be assessed additional fees by the collection agency and may be reported to one or more of the national credit bureaus.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. Birkam Health Center provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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Patient or Guardian Signature Date

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Printed Patient Name (and Guardian Name if applicable)

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Witness