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PATIENT FINANCIAL RESPONSIBILITY

Today's Date/Date of Service: _____

Patient Name: _____

Patient Date of Birth: _____

Responsible Party: _____

Insurance Plan: _____

Type of Exam: _____

I agree to be responsible for payment of any examination or procedure not authorized or deemed necessary by my insurance company, Medicare, or Medi-Cal. I agree to pay the balance of what my insurance might not pay.

Signature: _____ Date: _____