

CAPITAL OB/GYN, INC.

Obstetrics Gynecology

77 Cadillac Drive, Suite 230
Sacramento, CA 95825

2101 Stone Blvd., Suite 110
West Sacramento, CA 95691

FINANCIAL RESPONSIBILITY AGREEMENT

Patient _____ **Date**
Name: _____ **of Birth:** _____

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits.

I understand and agree it is my responsibility and **not** the responsibility of the Physician or Capital OB/GYN, Inc. to know if my insurance will pay for my medical services or visits.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

Signature: _____ **Date:** _____
(please sign here – Patient or Responsible Party)

Responsible Party Name: _____
(please print name of Responsible Party if different from Patient)