ACKNOWLEDGMENT OF FINANCIAL OBLIGATIONS

FINANCIAL AGREEMENT & INSURANCE INFORMATION

I/we hereby agree to pay all charges due or that become due to Princeton Wound Care Center for care and treatment. Benefits, if any, paid to PRINCETON WOUND CARE CENTER by a third party, will be credited to your account. The patient and/or the undersigned will be responsible for any remaining balance.

ASSIGNMENT OF INSURANCE

I hereby authorize payment directly to Princeton Wound Care Center of any benefits payable for services provided under the policy(s) or plan(s) issued to me by my insurance carrier(s). If I receive payment from my carrier for benefits due Princeton Wound Care Center for my care, other than as reimbursement for payments I made for covered services, I agree to promptly sign such payments to Princeton Wound Care Center, or make payments in such amounts directly to you.

RELEASE OF INFORMATION

I authorize Princeton Wound Care Center, the doctors who treat me, & their authorized representatives, to use and disclose my health information for any reason necessary for treatment, payment, and health care operations. These purposes include but are not limited to any release of information that my insurance company asks for & any information needed to plan my discharge.

FINANCIAL LIABILITY

I understand that I am personally responsible to pay for my care at Princeton Wound Care Center, if I do not have insurance or my insurance does not pay for my care because:

- My health plan requires my own doctor (a Primary Care Physician or PCP) to give me a written referral before you treat me, and I did not get a referral
- My health plan denies payment for these services and leaves me responsible for payment
- My health plan decides that these services are NOT covered by my plan. The same service might be covered at a different hospital or office
- My health plan coverage has lapsed or expired at the time I receive services at Princeton Wound Care Center, &/or
- I have chosen not to use my health plan coverage.

I agree to pay the amounts my health plan agreement requires. I understand you ask me to pay at or before the time of service. I understand you will send me a final bill after discharge. I understand I am expected to pay the bill in full within the stated reasonably expected time. If I am unable to pay my bill or payment presents a hardship, I understand I could be eligible for help through a financial assistance program.

PROFESSIONAL SERVICES

I understand certain physicians or other licensed professionals (such nurse practitioners) may provide medical services to me while I am at PRINCETON WOUND CARE CENTER, such as: wound care, debridement, non-invasive vascular testing, interpretation of tests, & that these charges are not included in my clinic visit charges. I understand that **some of these physicians may not provide services in my presence, but are actively involved in my diagnosis and treatment. I acknowledge that, because of operational needs and schedules, you cannot guarantee that every doctor assigned to my care participates in my insurance plan.** I hereby authorize payment directly to such physicians or physician practices under the policy(s) or plan(s) issued to me by my insurance carrier(s). I agree to pay all charges due or that become due with respect to such services to the extent the charge is due after credit is given for benefits paid on my behalf by any third party payer (insurance plan, etc.)

I understand all the information listed above, which has been fully explained to me.

______________________________	____________________	__________
Signature of Patient (or Financially Responsible Party)	*Relationship to Patient*	*Date*