MADISON FAMILY CLINIC
2161 Lexington Road, 1st Floor, Suite 5
Richmond, KY 40475
Phone: 859-626-7794 - Fax: 859-626-7764
E-mail: info@madisonfamilyclinic.com

Agreement of Financial Responsibility

1. The client is responsible for seeing that the office has a current copy of client's insurance card. For monthly renewals, this will need to be done on at least a monthly basis. **ANY** charges denied as a result of this office nor receiving correct, current insurance information will be billed to the client.

2. The client is responsible for assuring that **any** changes in insurance coverage, current address, and phone numbers are reported to the office.

3. If the client has an insurance carrier that requires them to select a primary care provider, such changes must be completed by the third visit to this clinic.

4. All applicable co-payments are due at the time services are rendered unless prior arrangements have been made.

5. Any services not covered by your insurance carrier will be the client's responsibility. Special consideration may be made for particular insurance carriers.

6. If the client carries and outstanding balance on his/her account, a payment plan must be executed prior to further services being rendered.

7. If the client is presenting for psychiatric services, authorization must be obtained from the respective insurance carrier prior to the first visit. If the client is given an authorization or pre-certification number, that number must be provided prior to the initial visit.

The above was discussed with ______________________________________

and agreed upon on this date_________________________.

Client Signature: ____

Billing Representative: ____

Advised of Practice No-Show Policy: ______________________________ **(Initial)**

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