CEDARS-SINAI

Financial Responsibility Form

Dear Patient:

Positive verification of your coverage cannot be made at this time.

You will receive services today with the understanding that in the event your coverage is not effective, you will be billed and held financially responsible for these services rendered.

Patient Name: _____ MRN: _____

Date: _____

Address: _____

Home Number: _____ Work Number: _____

Insured Subscriber's Name: _____

Insured Subscriber's Date of Birth: _____

Name of Employer: _____

Name of Insurance Company: _____

AGREEMENT

I have read the above and understand my possible financial responsibility for services rendered and hereby affix my signature as an acknowledgment of this understanding.

_____ _____

Patient Name: Patient MRN:

_____ _____

Signature*: Date:

Employee Initials: _____