SHABIH KHAN, M.D.
INTERNAL MEDICINE

835 WEST CHESTER PIKE • WEST CHESTER, PA 19382 • TEL (610) 696-0127 • FAX (610) 696-0177

HOSPITAL CARE SPECIALISTS, LLC
STATEMENT OF FINANCIAL RESPONSIBILITY

- I (or patient's guardian) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing your contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, or most major credit cards.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but not limited to):
  - Charge for returned checks
  - Charge for copying of patient medical records
  - Charge for forms completion
  - Charge for missed/rescheduled appointments

I understand that if I do not pay the "patient due" balance in a timely manner it could be sent to a collection agency and may be asked to leave the practice. I also understand that an additional 35% of my outstanding balance will be added to the amount due to cover the costs of collections. I agree to pay this cost in addition to the outstanding balance for services rendered.

I understand that a $50 fee may be charged for missed/rescheduled appointment changed less than 1 business day in advance. I also understand that a reminder call is a courtesy and that it is my responsibility to know when my appointment is scheduled. I understand that if I miss 3 appointments without proper notice I may be asked to leave the practice. I understand that a $25 fee will be charged for any returned check fees.

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Hospital Care Specialists, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Assignment of Insurance Benefits

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Signature of Patient, Guardian or Authorized Representative