Sunshine Women's Care
OB/GYN Services

Dr. Fangxian Lu MD PhD
4732 Sugar Grove Blvd. Suite 600
Stafford, TX 77477
Ph: (281)302-5026

Financial Statement

PATIENT_____ DOB:_____

PATIENT RESPONSIBILITIES

In order to receive proper care, patients must accept certain responsibilities. You are responsible for providing accurate and complete information regarding your Insurance policy(ies). You are responsible for your financial obligation.

FINANCIAL TREATMENT

In consideration of the services to be rendered to the patient and/or the legally responsible person signing this Consent assumes full financial responsibility for the payment of the patient's account. If the account is referred to an attorney or collection agency, the same person agrees to pay actual attorney's fees and collection expense. If charity services are required, eligibility determination should be requested upon first visit or receipt of itemized bill or statement.

IRREVOCABLE ASSIGNMENT OF INSlJRA1'\CE BENEFITS

I hereby authorize and direct all Insurance company (ies) under which I am insured to pay directly to Sunshine Women's Care Clinic PLLC for all charges incurred, or alternatively, for all charges in excess of the sums actually paid by the said policy(ies). Each person signing the Consent is financially responsible for charges not collected by this assignment.

RELEASE OF INFORMATION

To the extent necessary to determine liability for payment and to obtain reimbursement, I Authorize Sunshine Women's Care Clinic PLLC to disclose my health care information to any person, Social Security Administration, Insurance or benefit payor, health benefit plan or worker's compensation carrier which is, or may be, liable for all or a portion of the physician's charges, and to complete claim forms on behalf of the patient. I understand that Sunshine Women's Care Clinic PLLC may disclose my health care information without my written authorization to: members of audit, quality assurance, applicable State and Federal agencies; or to a court pursuant to a court order or Subpoena. I also understand that my health care information will not be provided to any person including next to kin, close personal friends, florists, delivery personnel or physicians who are not currently treating me without my written authorization.

FOR MEDICARE PATIENTS

ADVANCE BENEFICIARY NOTICE THAT MEDICARE WILL NOT PAY

Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare, benefits and Medicare will not pay for them. When you receive and item or service that is not covered, you are responsible to pay for it, personally or through any other insurance that you may have.

DECLARATION

I have read and understand the above agreements, authorizations, and irrevocable assignments. The terms and consequences of this document have been fully explained to me and I have signed it freely without inducement other than the rendition of services. All questions have been fully answered. I do understand the above agreements, authorizations, and irrevocable assignments. I do understand that I am responsible for any amount not covered by Insurance.

_____	_____	_____
Patient/Guardian Signature	Print Name	Date
_____	_____	_____
Witness	Print Name	Date