Statement of FINANCIAL RESPONSIBILITY

Patient Name: _____ Date: _____
Acct #: _____

Dr. Gianni Faedda appreciates the confidence you have shown in choosing us to provide for your medical needs.

The service you have selected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will bill you monthly.

However, you are ultimately responsible for the payment of your bill and any interest accrued if you are late in paying your bill. An interest of 2% monthly will be charged on bills outstanding longer than 30 days.

You are responsible for payment of your fee at the time of service, and upon receipt of a bill for any of your account balance.

I have read the above policy regarding my financial responsibility to Dr. Gianni Faedda for providing medical services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate.

I agree to pay Dr. Gianni Faedda the full and entire amount of all bills incurred by me or the above named patient, if applicable.

NAME (Sign and Print) _____

RELATIONSHIP (to Patient) _____

DATE_____

BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call us inquire about your personal health information or billing information. Please take a few moments to complete this section. I authorize Dr. Gianni Faedda to disclose my health information that is directly related to my current treatment at his office to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.
Such persons involved in your care may include: spouse, children, blood relatives, roommates, a boyfriend or girlfriend, domestic partner, neighbors and colleagues.

NAME (Sign and Print) _____

RELATIONSHIP (to Patient) _____

DATE_____