Doylestown Health
Physicians

1. **ASSIGNMENT OF BENEFITS:** I hereby assign to Doylestown Health Physicians all benefits payable to me for my care and/or treatment.

2. **FINANCIAL AGREEMENT:** I agree to be responsible for charges not covered by insurance. In consideration of the service to be rendered, I acknowledge the obligation to pay Doylestown Health Physicians in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collection, to pay reasonable attorney's fees and collection expenses. I acknowledge that I am responsible for any copay and coinsurance at the time of service. I understand that Doylestown Health Physicians reserves the right to charge a fee for any checks returned for non-payment. I understand that the obligation to pay Doylestown Health Physicians may not be deferred for any reason, including pending legal action against other parties to recover medical costs.

3. **CONSENT FOR TREATMENT:** I understand the medical care I will be receiving will be ordered by my physicians or their designees as is necessary in their judgment. I also understand and agree that my treatment may include taking of photographs for clinical and educational/teaching purposes. If photographs are used for my treatment, they will become part of my medical record. If used for educational/teaching purposes, photographs will not contain personal identifiers.

4. **FINANCIAL ASSISTANCE:** If you are unable to meet your financial obligation, financial counselors are available to assist you. Please call 267-893-6427 for more information.

5. **CONSENT TO CONTACT:** If, at any time, I provide a telephone number (including cell phone), email address or similar electronic means to communicate with me, I consent to receive such communications (including autodialed calls and prerecorded messages) from Doylestown Health Physicians, its affiliates, employees, agents and independent contractors, including collection agents regarding the services rendered and/or my related financial obligations.

6. **FOR MEDICARE PATIENTS:** I certify the information I have provided in applying for payment under the Title XVIII of the Social Security Act is correct. I am aware that I may incur a coinsurance liability for outpatient service(s) provided by Doylestown Health Physicians as well as the hospital.

7. **HIPAA:** I acknowledge that Doylestown Health's Notice of Privacy Practices has either been provided or made available to me.

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Signature of Patient/Authorized Representative Date

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**By signing above, I hereby acknowledge that I have read this form and have had the opportunity to ask questions and have them answered.**

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Signature of Witness Date