FINANCIAL RESPONSIBILITY AGREEMENT

Family Care Associates of Blair County DBA Quantum HealthCare Services LLC
James Frommer DO
125 Carson Valley Road
Duncansville, PA 16635
Phone: 582-465-7008

Patient Name (Print): _____ DOB: _____

I, the above-named patient, understand that I am financially responsible for all services provided to me by James Frommer DO of Family Care Associates of Blair County DBA Quantum HealthCare Services, LLC.

- I agree to pay for all services provided to me by the healthcare provider or clinic at the time services are rendered.
- I agree to provide accurate and complete insurance information and to notify the healthcare provider or clinic of any changes in my insurance coverage. I understand that I am responsible for any amounts not covered by my insurance plan.
- I acknowledge that I am responsible for paying any co-payments, deductibles, or other out-of-pocket expenses at the time of service. If I am unable to pay for the services provided, I agree to make payment arrangements with the healthcare provider or clinic.
- I authorize the healthcare provider or clinic to release any necessary information to my insurance company or any other party responsible for payment of my healthcare services.
- I agree to provide the healthcare provider or clinic with updated contact information, including my mailing address, phone number, and email address.
- I understand that failure to pay for services provided may result in the healthcare provider or clinic taking legal action to collect payment, and that I may be responsible for any legal fees and expenses incurred by the healthcare provider or clinic in such an action.

By signing below, I acknowledge that I have read and understand the financial responsibility agreement and agree to comply with its terms.

Patient Signature: _____ Date: _____

Representative Name: ______________________________________ Relationship:

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