LAMONT W. HORNBECK, M.D.
Clinical Dermatology and Cutaneous Surgery
729 Sunrise Ave, Suite 700
Roseville, CA 95661
(916) 782-3721

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing **Lamont Hornbeck, MD INC** as your healthcare provider for your Dermatologic needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this to acknowledge your understanding of our patient financial policies in effect as of 1/1/2021.

Patient Financial Responsibilities

The patient (patient's guardian, if a minor or responsible for patient care) is ultimately responsible for the payment for treatment and care.

We are happy to bill your insurance for you, however, the patient is required to provide the most correct and updated information regarding your insurance.

Patients are responsible for payment of co-pays, co-insurance, deductibles, and all other procedures and/or treatments not covered by their insurance plan.

Co-pays are due at the time of service.

Co-insurance, deductibles and non-covered items are due **30 days** from receipt of billing.

Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include but not limited to:

Charge for returned checks
Charge for missed appointments without 24 hours' notice

By my signature below, I hereby authorize assignment of financial benefits directly to **Lamont Hornbeck, MD INC**, and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Form.

Patient Name

Signature of patient or guardian

Date