



Dr. Nimra Rana

651 Route 73 N, Suite 307, Marlton, NJ

Phone 856 275-6780 info@mdhealthclinicmarlton.com

www.mdhealthclinicmarlton.com

Patient Financial Responsibility Form

Patient Name: _____

Date of Birth: _____

Date of Service: _____

Insurance & Payment Responsibility Acknowledgment

I understand that my insurance benefits have been verified based on the information available at the time of verification. The eligibility check may include details such as copay, coinsurance, deductible, and other potential patient responsibilities.

I acknowledge that:

- I am responsible for any copay, coinsurance, deductible, or non-covered services assigned by my insurance company.
- Any remaining balance after insurance processing is my responsibility and must be paid according to the provider's payment policies.
- If my insurance denies payment due to coverage limitations, eligibility issues, or non-covered services, I agree to be responsible for the outstanding balance.

By signing below, I confirm that I have been informed of my potential financial responsibility and agree to fulfill any balance assigned by my insurance company.

Patient/Responsible Party Name: _____

Date: _____

Signature: _____