Financial Responsibility Agreement

“Responsible Party” (named below) accepts full financial responsibility for all services rendered to “Patient” (named below) by Brent Frazee, MD. If billing insurance, Responsible Party agrees to pay all copays, deductibles, coinsurance, and charges for non-covered services, and understands that insurance coverage is not guaranteed. Responsible Party agrees to pay any fees incurred for appointments that are missed or cancelled with less than 24 hours notice, and for excessive cancellations as defined by the Office Policies & Practice Agreement.

Patient consents to Responsible Party’s assumption of financial responsibility for Patient’s treatment, and authorizes Brent Frazee, MD to communicate with Responsible Party to the extent necessary to conduct billing and collection of payment.

Responsible Party name (first, middle initial, last)	Responsible Party date of birth
Responsible Party home address	Responsible Party phone number
City State Zip	Responsible Party email address
Responsible Party signature	Date

Patient name (first, middle initial, last)	Patient date of birth
Patient signature	Date

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