Phone: 866-722-4806
Fax: 866-433-3965
www.CereScan.com

Patient Responsibility Agreement

I, ____________________________, understand that my insurance company will be billed for applicable out-of-network charges related to services provided to me by CereHealth MSO, LLC (“CereScan”).

I understand that after CereScan receives reimbursement, if any, from my insurance company, there may be a balance remaining or additional charges assigned to me, such as a remaining annual deductible, member copay or other out of pocket costs. By signing this form, I agree that any and all remaining balance due after my insurance company pays its portion for out-of-network services to CereScan, is my responsibility to pay.

In the event that my insurance company denies all claims submitted by CereScan, I agree that the maximum amount I will be liable for and which shall be charged to me for services I received will not exceed the cash pay amount.

I further understand that I will receive a statement from CereScan itemizing the cost of the services I received, any amounts paid to CereScan by my insurance company, if any, and the unpaid balance that will be applied to my credit card.

By signing this form, I agree to pay any balance owed for the services I receive. In the event that there are any problems with my payment, I agree to pay all fees incurred in collecting the account balance, including but not limited to, collection costs and legal fees.

____
Signature:

____
Name (printed):

____
Date:

All questions should be directed to a CereScan Patient Care Coordinator at **866-722-4806.**

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