CereScan®

Patient Responsibility Agreement

I, _____, understand that my insurance company will be billed for applicable charges related to covered services provided to me by CereHealth Corp. ("CereScan").

I understand any quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

I understand that my insurance company may determine that the covered services are not medically necessary for my stated medical indications. If 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 if my insurance company denies any claim(s), I will receive a statement from CereScan itemizing the cost of the services I received, any co-pay amounts paid to CereScan, if any, and the unpaid balance that I will be liable for.

By signing this form, I acknowledge that I have been notified that: (i) The services provided may not be covered by my insurance company; (ii) I have had the opportunity to discuss any potential financial obligations and still wish to receive the medical services from CereScan; and (iii) I will be responsible for any such medical services. If 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 of Birth _____

Date: _____

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