SC Professional Services, LLC
d/b/a Hope Integrative Medicine
775 Saint James Avenue, Suite B
Goose Creek, SC 29445
Phone: 843.779.7718

Patient Responsibility Form

1. **Patient's Financial Responsibility**
   - I understand that I am financially responsible for my health insurance deductible, coinsurance, copay, or non-covered service.
   - Copayments/Co-Insurance are due at time of service.
   - If my plan requires a referral, I must obtain it prior to my visit.
   - In the event that my health insurance plan determines a service "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
   - If I am uninsured or self pay, I agree to pay for the medical services rendered to me at the time of service.

2. **Insurance Authorization for Assignment of Benefits**
   - I hereby authorize direct payment of medical services to Hope Integrative Medicine on my behalf for any services furnished to me by the providers.

3. **Authorization to Release Records**
   - I hereby authorize Hope Integrative Medicine to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatments or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. **Medicare Request for Payment**
   - I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me or in Hope Integrative Medicine. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits related services.

_____ _____
Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____
Printed Name of Patient, Authorized Representative of Responsible Party Date