HEALTH FIRST COLORADO PATIENT FINANCIAL AGREEMENT AND GUARANTEE

Patient/Client Name _____

I, the undersigned, acknowledge that not all services provided to me by Endocrinology Specialists of Colorado, LLC ("Provider") are covered or reimbursable by my insurance plan, including Colorado's medical assistance program, the Health First Colorado Medicaid Plan (the "Plan"). I acknowledge and accept that I am financially responsible for all services and items rendered on my behalf by the Provider by which a charge may be associated and which is not covered and/or not reimbursable. I agree to give the Provider complete and accurate insurance information for primary and secondary insurance coverage and all identification and benefit cards/ documents required for claim accuracy.

I accept personal responsibility for all co-payments, deductibles, non-covered services and items, and non-reimbursable services and items, as dictated by my insurance coverage, including any non-covered services and items and non-reimbursable services and items under the Plan, plus any collection costs for amounts personally owed by me for services and items provided. I have been informed that the services and items provided may not be covered or reimbursable by my insurance plan, including the Plan. I elect to proceed with service with the understanding that I may be personally responsible to pay for the non-covered and/or non-reimbursable services and items being rendered to me.

_____

Patient Signature

_____

Date

_____

Parent or Legal Guardian Signature for a Minor Patient (if applicable)

_____

Date