Citrus Pulmonary Consultants and Sleep Disorders Center
5616 West Norvell Bryant Highway, Crystal River, Florida 34429
Ph: (352)795-1999 Fax: (352)795-2269
Manoj Shukla, MD Vikram Shah, MD Sunoj Abraham, MD
Oliver Sevilla, MD Fagun Modi, MD Gaurav Shah, MD

Financial Responsibility Statement

Patient/Responsible Party Information

Patient Name:_____ Social Security Number:_____

Patient's Responsible Party (if not self):_____ Patient Account Number:_____

Patient's Address:_____

Responsible Party Address (if different):_____

Financial Information

Total Household Monthly Income:_____

If no income, how do you support yourself?_____ Name of Person who supports you:_____

Name/Age of all household members:_____

Savings Account:_____ Account Number:_____XXX___ Current Balance:_____

Checking Account:_____ Account Number:_____XXX___ Current Balance:_____

Credit Card Accounts:
Name:_____ Balance:_____
Name:_____ Balance:_____
Name:_____ Balance:_____

Automobile(s):
Make:_____ Model:_____ Year:_____ Balance Due:_____
Make:_____ Model:_____ Year:_____ Balance Due:_____
Make:_____ Model:_____ Year:_____ Balance Due:_____

Loans and other Indebtedness

Creditor:_____ Balance:_____ Monthly Payment:_____
Creditor:_____ Balance:_____ Monthly Payment:_____
Creditor:_____ Balance:_____ Monthly Payment:_____

Documentation of income must be included for consideration. Per Federal Law, we are required to collect copayments for all Medicare patients.

Citrus Pulmonary Consultants and Sleep Disorders Center
5616 West Norvell Bryant Highway, Crystal River, Florida 34429
Ph: (352)795-1999 Fax: (352)795-2269
Manoj Shukla, MD Vikram Shah, MD Sunoj Abraham, MD
Oliver Sevilla, MD Fagun Modi, MD Gaurav Shah, MD

Monthly Expenses

	Amount
Rent/Mortgage	$
Food	$
Fuel	$
Utilities	$
Insurance	$
Clothing	$
Medicine	$
Water	$
Transportation	$
Telephone	$
School Supplies	$
Other	$

Total Expenses: _____
Total Income: _____
Surplus: _____

The patient's indigence must be determined by the physician, not by the patient. The physician must ask if any source other than the patient is legally responsible for the patient's medical bill, such as title XIX, local welfare agency, guardian, et cetera.

Assumption of Direct Financial Responsibility

❑ The undersigned shall be financially responsible for and agree to pay _____, upon tender of a statement thereof, for all services rendered to the patient, at the rate established by the physician in accordance with the usual charges for such services, and the obligation of the undersigned is an original, direct, independent, and positive promise to pay based on the exclusive credit of the undersigned, and is not a collateral or contingent promise to answer for the debt of another.

The physician's payment policies have been explained to the undersigned and the undersigned acknowledges and accepts responsibility for payment of all charges incurred with Citrus Pulmonary Consultants and Sleep Disorders Center.

❑ I am unable to pay the outstanding medical bill due to hardship.

Patient Signature:_____ Date:_____

Responsible Party Signature:_____ Date:_____
Relationship to Patient:_____

Witness Signature:_____ Date:_____

Practice Representative Name:_____
Practice Representative Signature:_____ Date:_____