**De Silva Medical Group, PC.**
1-844-475-3299
Fax: (404) 949-1848
PO Box 479, Villa Rica, GA 30801
www.desilvamedgroup.com
submitdocs@desilvamedgroup.com

# PAYMENT LIABILITY AGREEMENT

| _____ | _____ | _____ |
|---|---|---|
| **PATIENT NAME (FIRST, LAST, MI)** | **PATIENT DATE OF BIRTH** | **TODAYS DATE** |

This Agreement outlines the patient's financial responsibility for services provided by De Silva Medical Group, PC.

**1. Insurance Billing**

Our office will submit claims to your insurance provider using the information you have supplied. You understand that:

- Insurance coverage is **not guaranteed**, even after prior authorization or verification.
- Your insurance company determines final coverage and payment based on your plan.

**2. Patient Financial Responsibility**

By signing this Agreement, you acknowledge and agree that:

- You are **financially responsible** for any portion of charges **not covered**, reduced, or denied by your insurance.
- This includes, but is not limited to: deductibles, co-pays, co-insurance, non-covered services, out-of-network fees, and services denied as not medically necessary.
- You agree to pay the balance **in full** upon receipt of a statement.

**3. Accurate Insurance Information**

You agree to provide accurate and current insurance information. Failure to provide valid insurance details may result in the **entire balance** becoming your responsibility.

**4. Changes in Coverage**

You agree to notify us immediately of any changes to your insurance. If coverage changes or lapses, you are responsible for any charges not paid by your insurer.

**5. Payment Terms**

- Payment is due **within 30 days** of billing.
- Past-due balances may result in collections action or additional fees in accordance with office policy.

**6. Acknowledgment and Consent**

By signing, you confirm that you have read, understand, and agree to the terms of this Agreement.

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| _____ | _____ | _____ |
|---|---|---|
| **PATIENT SIGNATURE** | **PRINTED NAME** | **DATE** |
| _____ | _____ | _____ |
| **GUARANTOR SIGNATURE** | **PRINTED NAME** | **DATE** |

**If the guarantor is not the patient, both parties must sign.**

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