Financial Responsibility Agreement

Patient Name: ____ DOB: ___________________

By signing below, you agree to all of the following:

- I acknowledge that I am not covered by health insurance and instead participate in a Medical Cost-Sharing Program.
- I understand that Fox Valley Surgical Associates, Ltd., d/b/a Fox Valley Surgical Specialists ("FVSS") does not contract with my Medical Cost-Sharing Program or have any agreement for payment with this program.
- I understand that I am personally responsible for all amounts billed by FVSS for my care.
- I understand that FVSS will not accept any discounts to its billed charges that my Medical Cost-Sharing Program or its agents may request.
- I understand that FVSS will not accept correspondence or payment from my Medical Cost-Sharing Program or its agents and will not respond to such correspondence or cash any such checks.
- I understand that my failure to pay FVSS for care provided to me could result in a collections action being taken against me.

Signature: ____ Date: ______________________

If signing on behalf of another, relationship to the patient: ______________________________

If signing on behalf of another, printed name of person signing: __________________________