

Saint John's Health Center  
1328 22<sup>nd</sup> Street  
Santa Monica, Ca. 90404

**Financial Agreement**  
**for**  
**HMO/POS/EPO and PPO Patients**  
**Non-Verified or Non-Authorized Services**

**Patient Name:** \_\_\_\_\_

**Hospital Account Number L#** \_\_\_\_\_

**Physician Name:** \_\_\_\_\_

**Date of Service:**     -     -     \_\_\_\_\_     **Time:** \_\_\_\_\_

I understand that Saint John's Health Center cannot obtain verification or authorization from my insurance for payment of service rendered at this time.

I hereby agree to be financially responsible for any and all charges incurred for this visit if not covered by my insurance company.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Patient's Agent Signature

\_\_\_\_\_  
Time

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness Signature (SJH)

\_\_\_\_\_  
Date

PLACE LABEL or STAMP