Professional Nursing Service
2497 State Road
Cuyahoga Falls, OH 44223
330-929-5512

NOTIFICATION OF FINANCIAL RESPONSIBILITY

Thank you for selecting **Professional Nursing Service** as your home care provider. As a client of Professional Nursing Service you have the right to be informed of any potential financial obligation that may be incurred for services rendered. Total charges may change if Professional Nursing Service receives a change and/or request for additional medications, supplies and/or nursing services.

Professional Nursing Service will be providing services for:

Patient Name _____ SS # _____

Verification of Coverage:

Upon admission, **Professional Nursing Service** conducts a complete verification of your coverage. It is the verification that allows Professional Nursing Service to complete an assessment of your potential financial responsibility. Please be aware the verification of coverage is not a guarantee of payment. If for some reason your insurance company does not pay for any and/or all of your services, you will be responsible for any outstanding balance on the account.

- ☐ Professional Nursing Service was unable to verify your coverage with your insurance company. Due to our inability to determine your insurance coverage at this time, you are financially responsible for the total balance. Once contact is made with your insurance company your financial responsibility may change.

- ☐ You do not have coverage or have chosen not to utilize your benefits, therefore, you are financially responsible for the total balance.

- ☐ Professional Nursing Service verified your benefits with _____

Benefit	Verified (please circle)		Amount
Deductible	Yes	No	$ / unknown at this time if met
Out-of-pocket	Yes	No	$ / unknown at this time if met
Co-Pay	Yes	No	$ / unknown at this time
Patient Responsibility			
Nursing	$	/ Per Visit	unknown at this time
Home Health Aide	$	/ Per Hour / Per Visit	unknown at this time
Physical, Occupational or Speech Therapy	$	/ Per Visit	unknown at this time
Medical Social Worker	$	/ Per Visit	unknown at this time

Comments: _____

_____

_____

I hereby understand that I am financially responsible for any outstanding balance on my account. I have also acknowledged by signing this form that I have received the attached list of supplies.

Signature of the patient / responsible party and / or guardian

_____ Date _____

PNS Representative _____ Date _____