Sinai Health | Mount Sinai Hospital
Joseph & Wolf Lebovic Health Complex

600 University Avenue,
Toronto, Ontario, Canada, M5G 1X5

Patient Financial Responsibility Form

MRN: _____

Name: _____

Date of Appointment:

_____

Date Sent to Patient:

_____

Dear Patient,

Your care is our first concern.

Payment Information:

	Out of Province / Country		IFHP / Refugee Program		Community Health Centre
	UHIP		Uninsured / Self Pay		Military / RCMP / Federal

My Financial Responsibility:

I agree to pay for all hospitalization charges not covered by any other agency (OHIP, DVA, IVA, WSIB, Refugee Program) and any additional costs for which I am not insured or which are not entirely covered by my private insurance plan.

I agree to permit Mount Sinai Hospital to release my health information to my private insurer for the sole purpose of receiving payment for services provided

X_____

Patient/Guarantor:

My signature below indicates that I have read and understand all of the above and below clauses.

Patient Name _____

Signature _____

Date _____

Witness:

Print Name _____

Signature _____

Date _____

Credit Card Information: VISA / MASTER CARD ONLY

I authorize Mount Sinai Hospital to charge my credit card for costs not covered by Insurance or Other Agencies:

Credit Card Number: _____

Expiry Date ___/___

Name of Cardholder _____

Signature of Cardholder _____

Note: If the Patient is unable to read this notice, then it shall be read over and fully explained to the patient prior to signing. If the patient is unable to write, then the patient should sign with an 'W' and a witness, preferably a relative of the patient, should sign.