WE APPRECIATE THE OPPORTUNITY OF SERVING YOU

WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given unless prior arrangements have been specifically made. All accounts over 90 days will be charged an interest rate of 1 ½ percent per month (18% per annum) or a $2.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, whose costs will not exceed 30% of said unpaid balance, including a reasonable attorney's fee.

INSURANCE POLICY:

Insurance: Your current insurance card is required at the time of each check- in or must be on file in order for us to bill your charges to your insurance company. If we do not have a copy of your current insurance card, you will be required to pay for services rendered. When the card is provided we will, at that time, file the claim to your insurance and reimburse you after the claim has been paid. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations; this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION TO PAY:

I hereby authorize payment directly to the business office of this physician/clinic for surgical and or medical benefits, if any, otherwise payable to me for services rendered.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the staff to release any medical information including photographs of my condition, diagnostic information, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the staff deems it necessary in order to ensure that best medical care on my behalf. I further understand that any person(s) who receive(s) these medical records will not release any of the medical information obtained by this authorization to any other person or organization without further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

Signed:_____ Date:_____

IN CASE OF EMERGENCY PLEASE CONTACT:

Name:_____

Phone number:_____ Relationship:_____

Address:_____