Payment Responsibility Acknowledgement

All professional services rendered are charged to the patient. I understand that I am responsible for payment of all fees not paid or covered by insurance.

Patient's insurance co-pays, deductibles, and other estimated patient responsibility amounts are to be paid at the time of service. Any fee, co-insurance, or payment estimates given are not guaranteed and may differ from the actual fees, benefits or payments applied by the insurance company.

I authorize the release of any medical or other information necessary to process all medical claims. I also authorize payment of medical benefits either to myself or to the party who accepts assignment.

I understand I am responsible for contacting the physician's office to obtain results of any lab, x-ray, or pathology tests and to schedule follow-up treatment/office visits.

I have read the above, understand and agree to the aforementioned policies.

Print Patient Name: ______________________________________

Patient Signature: ____ Date: _________________

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