RESPONSIBLE PARTY INFORMATION

It is customary to pay cash for services at the time they are rendered. If you have an insurance plan, we will be happy to file the claim for you, HOWEVER, the responsibility for payment will remain with you. **You must supply us with complete information about your coverage including any necessary forms and numbers.** We will mail monthly statements to you to keep you informed when or if your insurance company pays. PLEASE CHECK WHICH APPLIES:

____I have provided my insurance information to office staff who has agreed to bill my insurance as a courtesy (not a responsibility). I will pay any applicable co payment (deposit) and/or charges for non-covered services at time of service and be billed for any remaining balance after insurance consideration.

___I will pay at time of service. I do not have insurance.

IF RESPONSIBLE PARTY IS OTHER THAN PATIENT, PLEASE PROVIDE INFORMATION

NAME_____

MAILING ADDRESS_____

HOME PHONE_____ WORK PHONE_____

SS#_____

I understand payment of the balance in full is required whether or not payment from any insurance company has occurred after 60 days. Finance charges of 1.5% will incur after 60 days. I authorize release of medical records to my physician or insurance company.

_____

Signature

_____