ALL FEES ARE DUE AT THE TIME OF SERVICE UNLESS OTHERWISE DISCUSSED

Method of payment: (Choose one) ❑ Cash ❑ Visa ❑ Mastercard ❑ AmEx ❑ Discover

I AM COVERED UNDER THE FOLLOWING INSURANCE POLICIES:

Medical Insurance Carrier: _____

I hereby authorize the release of any medical information and assign all insurance benefits to the doctors. I understand that I am financially responsible to the doctor for all of my charges incurred during the course of my treatment. Even though I may have insurance or other third party coverage, I understand any balance not paid or covered by my insurance carrier is my responsibility and is to be paid in full by me when due. In event of default and this account is placed with a 3rd party collection agency, I agree to pay add on collection charges in the amount of 33.33% of the unpaid balance. In the event of default, I recognize that legal proceedings may result and I agree to pay all costs of collection, including measurable attorney's fees. I understand that certain insurance carriers and health organizations require referral from the designated primary care doctor prior to being seen by a specialist. It is the patient's responsibility to secure this authorization. It is understood that if the referrals was not secured or not approved that the patient is responsible for all charges. Any charges rejected as non-covered are also the responsibility of the patient.

_____ _____

SIGNATURE OF RESPONSIBILE PARTY TODAY'S DATE