*** IMPORTANT INFORMATION REGARDING YOUR ACCOUNT***

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred**.**

NOTICE OF "NON-COVERED" SERVICES

I am aware that some services performed by the Practice may be considered "non-covered" by my insurance carrier or Medicare, therefore I will become fully responsible for payment of these services.

WAIVER OF "USUAL, CUSTOMARY AND REASONABLE" CLAUSES

(For patients with "UCR" coverage) I acknowledge that the fees charged by the Practice for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary and reasonable", due to specialized services and staff. However, I agree to pay the Practice fees in full, even if the amount is greater than what I am reimbursed for from my insurance company.

BILL TO/PAYMENT INSTRUCTIONS

☐ **COMMERCIAL INSURANCE/ THIRD PARTY PAYOR** Initial ☐ **MEDICARE** Initial ☐ ***MEDIGAP** Initial

I hereby authorize the Practice to bill my insurance company and/or Medicare (indicated or initialed above) for services provided to me and request that payments for such services to made to the Practice on my behalf.

*** IF MEDIGAP** _____ _____ _____

Name of Beneficiary | Medigap Policy Number | Health Insurance Claim Number

LIST NAMES OF THOSE WITH WHOM YOU WANT US TO SHARE YOUR HEALTH INFORMATION:

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____

PERMISSION FOR TREATMENT

Permission is hereby granted for physicians, employees or agents of the Practice to render the patient named below such medical and surgical treatment as is deemed necessary.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with the Practice's Notice of Privacy Practices that provides a description of Protected Health Information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this statement. I understand that the Practice reserves the right to change its Notice of Privacy Practices that will be effective for health information the Practice already has about me, as well as any they receive in the future. The Practice will post a current copy of the Notice. I understand that I may obtain a copy of the current Notice in effect upon request.

I have read all of the above and understand/agree to all provisions therein regarding responsibility for payment, permission for treatment, and Notice of Privacy Practices.

Patient's Name: _____

(Please Print)

Patient or (Legal Guardian's) Signature: _____ Date: _____

If Legal Guardian, Relationship to Patient: _____

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