ACKNOWLEDGEMENTS

PLEASE READ CAREFULLY

All professional fees are for services rendered to the patient. The patient is responsible, therefore, for all fees regardless of insurance coverage.

I understand I must report all insurance coverage even if different companies may be involved. It is illegal for a patient to withhold insurance coverage. If a patient has more than one insurance, it is the patient's responsibility to let the staff know of any and all insurance changes. This should be done within thirty (30) days.

I authorize the physician to release all information available for diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment to my insurance company and/or its representatives. Assignment of benefits are allow as designated by this office.

I understand the physician may release records for the purpose of treatment, payment or operation services.

I understand if for any reason the insurance company should fail to cover medical expenses, I will be held responsible for full compensation for medical services. This payment includes any deductibles coinsurance, copay or any fee that is not covered by my policy for any reason.

I agree that this authorization shall be valid until replaced by on at a later date.

I understand should I fail to pay any or all of the debt incurred for medical services, attorney fees and collection fees, a maximum of forty per cent (40%) and court costs will be added to my outstanding debt in addition to the balance due at time of default.

Patient signature ___________________________________

Date ____

Guardian signature _________________________________