Financial Consent

I understand that responsibility for payment of medical services in this office for myself and my dependents is mine; due and payable at the time services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30% and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly).

Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I also assign all benefits to Provider. I authorize the submission of claims without obtaining my signature on each and every claim submitted.

I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996.

I hereby authorize this Provider and its employees, agents and assignees to contact me via e-mail, text messaging and to my cellular devices.

Responsible Party's
Signature____Date_________________________