I,_____ agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time services are rendered.

_____(signature) _____(date)

If there should be a balance on my account after my deductible, co-pay and insurance payments have been made I understand that a statement will be mailed to me. I understand that a 0.83% late fee may be added to any account over 30 days old. I understand that if I do not make payment arrangements within 30 days of a balance owed my account may be turned over to a collection agency and I will be responsible for any additional fees assessed by that company. _____(initials)

INSURANCE : Our office is contracted with many insurance plans however, It is **your** responsibility to know the specific details about *your* plan and to verify that our office is an in-network provider. The estimates we give are based on information given to us by *your* insurance company and are never a guarantee. In order to submit claims on your behalf we will need a copy of your insurance card and driver's license. _____(initials)

BROKEN APPOINTMENTS : I understand that it is my responsibility to call 24 hours in advance if I will be unable to keep an appointment that is reserved for me. I understand a broken appointment fee of $50.00 will be charged without proper notification. _____ (initials)

Acknowledgement of Privacy Practices

I understand that this office recognizes the **HIPAA Privacy Practices** and a copy of this notice is available upon request. (Please print the name of any person(s) you will allow our office to give limited appointment information.)

Name_____ Name_____

Patient Signature _____ Date_____

Our office offers financing through Care Credit and Citi Healthcard

"We believe the brilliance of exceptional quality outshines the glimmer of a bargain deal"

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