Patient's Payment Consent Form

Patient Information

Patient's Legal Name: (Last) ---------- (First) ---------- (MI) ----------
Address ----------
City, State, Zip ----------
Home Phone Number ----------Mobile Phone Number----------Work Phone Number ----------
E-Mail Address ----------Date of Birth ----------

Responsible Party Information

Responsible party ---------- Guardian ---------- Guarantor ---------- Self
Check here if the address and telephone information is same as the patient ----------
Responsible party name (Last)---------- First---------- (MI ----------
Date of birth: MM----------/ DD----------/ YYYY----------, Sex ----------
Responsible Party Social Security Number ---------- Phone Number ----------
Address: ----------
City, State ----------, Zip----------

Patient's Insurance Information

Provide your insurance card (primary, secondary etc.) to the front desk at check-in
Insurance Name ----------Member Name ---------- Member Number ----------
Group Number----------Plan Number---------- Insurance Phone Number----------

Emergency Contact Information

Emergency contact name (Last)---------- (First)----------(MI)----------
Phone number---------- Do you have a willing will? ----- Yes -------- No
Emergency contact relationship to the patient----------, ---------- Guardian
Address----------, City----------, State ----------, ZIP--------

Payment Policy

It is our intent to provide best medical care to our patients. But we also need patient's cooperation. This entails prompt payment of our services. Please note our following policies for payment of our services.

1) All co-payments and non-covered items are to be paid at the time of visit to our practice.
2) You are responsible for payment of all charges, including any balance due following insurance payment.
3) We reserve the right to charge interest at 1 ½ % per month (18 % per annum) on balances 30 days and older. In the event any balance due hereafter is not paid as agreed, the undersigned jointly and severally agree to pay all costs incurred in the said and unpaid balance, including reasonable collection agency and attorney's fees.
4) If you are a Medicare patient, when you receive services that are not benefits of Medicare, you are responsible to pay for them personally.

I understand and agree to the terms set forth above.

Signature of patient or personal representative ----------

Date ----------

Print name of the patient or personal representative----------

Relationship to the patient----------