2024 Patient Signature

COMPANY NAME: _____

PATIENT NAME: _____

PLEASE INITIAL EACH BRACKET, DO NOT CHECK MARK OR MAKE AN X

____ *Consent for Care and Treatment*

I, the undersigned, hereby agree and give my consent for above named practice to furnish care and treatment considered necessary and proper in treating my condition.

____ *Authorization for Signature on File and Release of Information*

I, the undersigned, hereby authorize the office of above named practice to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photostatted copy of this authorization shall be as valid as an original.

____ *Authorization for Assignment of Benefits*

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of above named practice, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to above named practice.

____ *Financial Responsibility*

I, the undersigned, understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

____ *Cancellation Policy*

Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24 hours notice so that we may reschedule your appointment and offer the reserved time to another patient. There will be a charge of $100.00 for NO SHOW appointments or cancellations with less than 24-hour notification. I, the undersigned, understand that I will be personally responsible for any cancellation fees.

____ *Reminder Message*

I, the undersigned, hereby authorize the office of above named practice to send reminders to my mobile number, home phone, or email address of upcoming appointments.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

_____ _____

Patient or Guardian Signature Date