Consents and Agreements - Please read - print name and sign

* All office visit fees must be paid at the time of visit (if your insurance does not cover office visits, or if you have no insurance) including copays and deductibles. As a courtesy, we will submit x-rays, surgeries, and procedures to one insurance carrier if we are not a member of that panel or a participant. *If these submissions are not processed and paid within 60 days from the date of service, then all fees will become your responsibility.*

* Patients are responsible for all insurance plan referrals requirements, HMO requirements, out of network processes and other restrictions that may apply to their policies.

Please indicate if you are paying copays or non covered services today by _____ check _____cash

We do not process or accept Credit cards, Debit cards, or Health Savings Cards. We are willing to wait for you to process your online HAS check payments, when you return home, immediately after your visit.

Please initial each below and then complete all applicable signature line(s).

_____I give permission for evaluation and treatment of my condition. I will inform the office of any treatments or procedures that I do not desire, at any time, or while options of care are being discussed.

_____I / we acknowledge that I / we am personally financially responsible for those charges not totally covered by insurance. Any invoices not paid when due will be charged a service charge (minimum five dollars) and 1 & ½% interest per month (18% annually) and any direct costs (eg. Postage, certified fees).

_____I am aware that charges are made for missed appointments or those without twenty four hours notice of cancellation. An answering machine is available 24/7.

_____For past due accounts, managed via the Magisterial District Justice Courts, I / we am aware that the customer is also liable for all collection costs, including court costs, office processing costs, and attorney fees.

_____Known co-pays and non-covered insurance items are due at the time of service. Carrying fees occur if payments are delayed. If you do not have payment with you, we trust patients and send an invoice home with you to then remit payment.

Patient Signature & Printed name

Spouse Signature & Printed Name

_____ _____

Parent Signature & Printed name (if minor child / child insured via parent) or **POA** signature

_____

Primary Insurance Holder Signature: Example: Spouse's employer or business provides employee insurance and patient is family member using this plan but not paying for the plan

_____

Special Note for out of town parents: If you are giving permission for your child to use your insurance, and if you want to be directly billed and responsible for co-payments, deductible charges and any other costs, please additionally sign here and provide both parent names, addresses, phone numbers and any other information.

Please contact your insurance provider to understand your Cost-Sharing for office services which may include the following:

Co-Pays - A fixed payment set by the insurance carrier, and often noted on your card (so you know in advance your minimum payment obligation) due a the time of each office visit. This is a "Specialist" office, so if more than one co-pay is listed, look for SP and the amount.

Co-Insurance - Often in addition to a co-pay, it is a percentage of an approved and covered service (not all services are covered), often starting After you Deductible is met. For example, your insurance begins paying 80% (you pay 20%) or insurance pays 90% (you pay 10%).

Deductible - The Out-Of-Pocket patients have agreed, via their insurance contract, to pay physicians before your benefits kick in. Generally, lower premiums mean higher deductibles, and vice versa (perhaps like your car insurance or home owners insurance if applicable).