

**PATIENT'S SIGNED STATEMENTS**  
**(PATIENT/GUARDIAN SIGNATURES)**

(PLEASE READ EACH SECTION CAREFULLY-SIGN & DATE WHERE INDICATED)

1. It is our financial policy to bill your insurance carrier where appropriate and collect the copay, coinsurance or full fee at the time the service is delivered. In the case of processing a claim to the insurance plan, a statement will be generated to the patient once the insurance payment is received. The patient must pay the amount in full within 30 days unless payment arrangements have been discussed prior to the service. If this payment is not received within 30 days, the account will be assessed an interest payment of 2% each 30 days thereafter. If the account is not completely paid in 90 days, the account will be referred to our collection agency.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

2. This office makes every reasonable attempt to keep all patient health information confidential. This office has a complete set of privacy practices available to all patients. An abbreviated version of the privacy practices is posted in our waiting room. The complete set is available upon request. I am aware of the privacy practices.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

3. Every patient's signature at the bottom of the health information sheet gives us signed consent to use the patient's information to process insurance claims, and share pertinent health information with other health care providers for the sole purpose of caring for our patients this may be done by phone, electronic billing, mail, or faxes). At times, other parties may ask for your information (attorneys, employers, claims agents...). This information will not be disclosed unless we have your signed authorization listing the party that you wish to receive the documentation. The authorization is for a one time event only. Your signed authorization, date, and party information will be kept on file.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

4. There may be situations where patients may request copies of their records. The office would need a written request signed by the patient and/or guardian 30 days before the issue of records. A photocopying fee of \$.25 per page will be collected when the request is made. The doctor's notes are handwritten, therefore, a consultation fee of \$70.00 will be charged to the patient for the doctor to translate his notes upon receipt of the record. This would be due at the time the translation is scheduled. If the patient would like to view the records without photocopying, the patient will be charged \$70.00 translation consultation due when the consultation is scheduled.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_