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## HIPAA/Financial Disclosure

I authorize the release of any information including the diagnosis and the records of any treatment or exam rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

All services rendered are on a cash basis unless otherwise arranged. Insurance will be billed as a convenience if current information is provided at the time of service.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

No assignment is accepted on Worker's Compensation or personal injury cases. Billing is done for primary insurance only.

Accounts past due 30 days subject to monthly \$2.50 service fee. Accounts 90 days past due subject to collection action.

A \$25 inconvenience charge will be placed on all returned checks.

I have fully read and understand the above information. I voluntarily affix my signature and the date below.

Patient Printed Name: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_  
(parent or guardian if patient is a minor)