I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself—not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable time period, upon request of this office, I will immediately pay the balance owed on my account unless otherwise agreed to in writing. I further understand and agree that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including but not limited to all court costs and attorney fees. I authorize this office to released any medical information relating to my treatment to any insurance companies that may be responsible for paying benefits to me, to any attorneys who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys or other payers. I have read, understood and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient signature_____Date_____