

PATIENT SIGNATURE ON FILE

All information that has been given thus far is accurate and true to the best of my knowledge. I understand that I am responsible for payment of services rendered, including reasonable attorney's fees and costs of collection in the event of default. **I further understand that if payment becomes 60 days past due, delinquency at the lesser of the annual rate of 30%, or the maximum allowable rate, will be due on the delinquent amounts from the date the payment was due.** I understand that Advanced Physical Medicine will bill my insurance company, but that I am ultimately responsible for any balance not covered by my insurance such as co-payments, deductibles, or uncovered services.

I request that payment of Medicare, Medigap, or other insurance carrier benefits be made on my behalf to Advanced Physical Medicine for services furnished to me.

I have been made aware of the amount or percentage that I will be responsible for. My responsibility is _____

Signature

Date

Insurance Policy/Identification Number

INFORMED CONSENT

I understand that I am receiving medical services/treatment at Advanced Physical Medicine and I have been advised that they are a non-participating provider with my insurance carrier. I do, however, have out of network benefits. It has been explained to me that I may be required to pay higher deductibles or co-pay amounts as determined by my insurance policy. I accept any remaining balance not paid by my insurance company as my responsibility.

Signature

Date

Witness Signature

Date