Client Name_____

Payment Information

Financially responsible party: Self • Other •

Please provide the following information about the Financially Responsible Person

Name: _____ Age: _____ SS# _____

Relationship to Client: _____Home phone: _____ Work Phone _____

Employer: _____ Occupation: _____

Billing Address: _____

Payment/Insurance Agreement & Authorization to Send Reimbursement Information

I accept responsibility for payment of charges for services rendered to the above-named Client. **I understand that full payment and/or my co-payment and/or deductibles are expected at the time services are rendered unless the doctor agrees otherwise.** I understand that, unless the above named Client has coverage under a managed health plan (e.g. HMO, PPO, EAP, etc) to which I subscribe and in which the doctor is a participating provider, I am personally responsible for the payment of all charges. I understand that, as a courtesy, the doctor will file insurance claims for the services provided; however, this does not release me of my responsibility for payment of the charges for services. Payment for any charges denied or not covered by my insurance company become my responsibility and I agree to pay these charges. I also understand that any court order I have is an agreement between myself and the courts NOT the doctor and I am still responsible for payment of all charges. I understand and agree that I may be charged for and **required to pay for missed appointments not cancelled at least 24 hours in advance**. I further understand and agree that a collection agency and/or the courts may be used in the event of delinquent payment, and I realize that such action could require that the doctor release to the collection agency, attorneys, and/or the courts, information which identifies the parties involved, gives the Client diagnoses, and describes the dates and nature of the charges, as well as all other information contained on any claim filed. In addition, if I have requested that the doctor file the charges to my insurance company, I understand that securing benefits under health insurance or other health plans will require that the doctor provide the plan management with confidential Client information, including diagnosis and the dates and type of service rendered. Further, I understand that for utilization review, quality assurance, and other claims review purposes, it may sometimes be necessary for the doctor to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and other case information. I fully and freely consent to the release of any and all such Client information as is necessary for the processing and review of health care claims made by or on behalf of the above named Client. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

_____ _____

Signature of adult Client or parent/legal guardian of Client less than 18 years of age or responsible party — Date

_____

Client Notification of Privacy Rights (HIPAA):

I, _____, understand and have been provided a copy of Dr. Molnar's Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

_____ _____

Client Signature or Parent if Minor or Legal Charge — Date

Describe Legal Charge: _____