Payment Information

Financially responsible party: Self □ Other □
Please provide the following information about the Financially Responsible Person
Name: _____ Age: _____ SS# _____

Relationship to patient: _____Home phone:_____ Work Phone _____

Employer: _____ Occupation: _____

Billing Address: _____

Payment Agreement

_____ I accept responsibility for payment of charges for services rendered to the above named patient. I understand that **full payment are expected at the time services are rendered**.

_____ I understand and agree that **I will be charged for and required to pay for missed appointments** not cancelled at least 24 hours in advance (late cancellation) or missed appointments with no notification (no show). You are encouraged to discuss missed appointment and no show fees with me.

_____ **Should it become necessary to employ a collection agency** and/or the courts in the event of delinquent payment, it is specifically agreed that the patient will pay all such costs, including reasonable attorney's fees and court costs

_____ A 1% per month (12% Annual Percentage Rate) **interest charge** will be added on all accounts that are not paid within 90 days of the billing date.

_____ I understand that **securing benefits under health insurance or other health plans** will require that the doctor provide the plan management with confidential patient information, including diagnosis and the dates and type of service rendered. 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 that may include case history, presenting problems, or treatment plans.

_____ I have read and understand the above procedures and agree to them.

I fully and freely consent to the release of any and all such patient information as is necessary to carry out the above stated policies for or on behalf of the above named patient. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

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

Patient Notification of Privacy Rights (HIPAA):

I, _____, understand and have been provided a copy of Dr. Molnars' Patient 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.

_____ _____
Patient Signature or Parent if Minor or Legal Charge — Date
Describe Legal Charge: _____