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Acknowledgment of Responsibility for Payment

I understand and acknowledge that I am financially responsible for all charges. Payment is due (cash or check) at the time of my visit. I also understand that the physician will provide sufficient information to file my own insurance claim.

The adult accompanying a minor is responsible for full payment. This is regardless of any divorce decree (which is a contract between the parents; not between you and your doctor). If an adult other than the adult accompanying a minor is responsible for a minor's bill, the adult accompanying the minor is responsible for paying the physician fees and may collect reimbursement from the responsible adult.

Parents are responsible for sending payments for unaccompanied minors at each visit. I have been informed of my doctor's cancellation policy and acknowledge that I am financially responsible for missed or cancelled appointments.

CANCELLATION POLICY:

Your appointment time is specifically set aside for you and you alone. **If you cancel or reschedule a visit without 24 hours (One business day) the cancellation fees are the price of the full appointment.**

By signing below, you state that you have read and agree to this Acknowledgement of Responsibility for Payment in its entirety.

Person Responsible for Payment:

Name (Please Print) ____

Signature_____________________________________ Date__________________________

Patient's Name (Please Print) _____________________________________