PATIENT CONSENT AND WAIVER FORM

I, _____, understand that I am or will be responsible for all charges associated with today's visit and any subsequent visits relating to the diagnosis, testing, and treatment of any conditions, including but not limited to the following items:

- **NO REFERRAL AT TIME OF VISIT:** If you did not bring or have a valid insurance authorization referral (if your insurance requires one) at the time of your visit and still wish to be seen, you will be responsible for all charges. This is different than a regular referral from another provider.

- **NO INSURANCE:** You will be responsible for all charges associated with all visits.

- **MISSED APPOINTMENTS:** All patients receive a reminder prior to the appointment as a courtesy. If an appointment is cancelled up to 24 hours prior to your appointment, you will not be charged. If you cancel without 24-hour notice (without an urgent circumstance), you will be charged $50.00 as an established patient and $100.00 as a new patient. If you fail to show for your follow up appointment, you will be charged $50.00. If you fail to show for your new patient appointment you will be charged $100.00. More than two consecutive same day cancellations or reschedules may result in discharge from the practice.

- **CHANGES IN INSURANCE:** Patients are obligated to inform our office of all insurance changes. All co-pays and fees are due in full at time of service.

- **DELINQUENT ACCOUNTS:** In the event that your account becomes delinquent, you will be liable for all reasonable collection/attorney fees plus filing cost and processing fees.

- **MEDICAL FORMS/RECORDS:** All forms will require 5 business days to process and completion of forms will have a fee of $25 per form or letter. The practice has the sole discretion to determine which, if any, forms or letters we will complete. Completion of forms will not be discussed via telephone. Some forms may require an additional office visit. Should you need printed medical records, there will be a fee of $.75 per page to be paid prior to completion.

_____ _____

Patient's Signature or Responsible Party Date