AJ PSYCHIATRY

PLEASE READ & COMPLETE

I agree to pay for all services rendered. I agree to pay my co-payment and/or deductible/coinsurance portion at the time of service. I understand that I will be held fully responsible for any services deemed as non-covered or denied by my health insurance company. I understand that I will be fully responsible for any amount not covered by my health insurance. I also fully understand that, if my insurance company requests accident details related to my treatment, or any other information requested by my insurance, that I will comply with the information requested of me within 10 days of notification either by my insurance or AJ Psychiatry PLLC, or I will be financially responsible. I understand that I may make payment either in the form of cash, verifiable check, and/or credit card. I understand that my failure to make payment may result in future collection activity as outlined by the Fair Debt Act, and that there will be a returned check fee imposed of $35 each time that a check is returned.

I certify that I am 18 years of age and/or the legal guardian of the patient. If I am the legal guardian/guarantor I understand that I am financially responsible for the patient. I assign insurance benefits for all treatment rendered to AJ Psychiatry PLLC. I agree to release all such medical information as may be necessary to insure payment of my claim(s).

_____

(*Signature of patient or legal guardian*)

_____

(*Printed name*)

_____ _____

(*Social Security Number*) (*D.O.B*)

Date: _____