



PATIENT FINANCIAL POLICY

Thank you for choosing *Palm Beach Brain & Spine* as your health care provider. We are committed to providing excellent care to all of our patients, and we will always do our best to achieve this goal, whether in the office or at the hospital. As in most medical practices, medical fee reimbursements continue to decrease while our costs continue to increase. We have implemented the Patient Financial Policy to help control costs so that we can always provide high-quality medical care.

We are happy to assist you by billing your insurance company and requesting that your insurance company remit the payments directly to our office. Of course, you are responsible for the annual deductible and any co-insurance requirements at the time of treatment. _____ **(Initial)**

I hereby authorize and direct payment for services rendered to me by Dr. Amos O. Dare. Please be advised that Dr. Amos O. Dare does not participate with any health plans. Regardless of my insurance benefits, if any, I understand that I am financially responsible for any fees of services provided. Please note that all overdue accounts will have a collection fee added. _____ **(Initial)**

I hereby authorize and agree that all future HCFA claim forms will read “signature on file” in box 13 and shall constitute authorization to accept this as a current and valid signature on file for all future claim forms submitted. _____ **(Initial)**

I have read the Patient Financial Policy and agree to abide by its terms, as well as authorize my insurance company to forward the explanation of benefits and related payments directly to *Palm Beach Brain & Spine*.

X _____
Patient Signature (Parent or Guardian, if minor)

Patient Social Security Number

Patient’s Name (Printed)

Date