RESPONSIBILITY AND CONSENT STATEMENT

I hereby authorize and request the performance of medical services for:
Patient Name_____DOB_____
Responsible Party Name_____Relationship_____
I also give my consent to any advisable and necessary medical procedures, medications, or anesthetics to be administered by the Attending Physician or by his supervised staff for diagnostic purposes or medical treatment.

I understand and acknowledge that payment is due at the time service is rendered. I further understand that I am financially responsible for the services provided for myself or the aboved named individual. Regardless of insuranc coverage on the day services are rendered.

INSURANCE NOTIFICATION

***I understand that *my insurance policy is a contract between my insurance carrier and myself*, not between the insurance company and Dr. McCurley and staff.**

- **I also understand that insurance policies vary greatly from one policy to the next, and that Dr. McCurley and his staff is not responsible for knowing the details of my policy.**
- **I understand that Dr. McCurley's office staff is authorized by Dr.McCurley to file my insurance as a courtesy to me. Only my primary insurance will be filed, and if I have a secondary insurance to file, it is my responsibility to file and obtain final payment of my balance.**
- **I agree that my insurance policy is a contract between me and my insurance company, and not the Doctor's office. I further understand that I am responsible for my bill if my insurance company does not remit payment within 120 days. I will remit payment and petition the insurance company on my own behalf.**
- **I agree to pay in full for my visit when my deductible has not been met. I understand that the claim will be filed on my behalf, with my insurance company.**

FEES

There is a $25 fee for the following services:

- **Completing paperwork for FMLA, records requests, or other papers and/or letters at my request.**
- **Duplication of medical records (if picked up by patient)**
  There is no fee to mail records to another Physcians office.
- **A no show charge after the first appointment missed without providing office with 24 hr notice.**
- **Returned check fee (may be higher if bank charges are higher).**
- **The undersigned has read and accepts the Internal Policies as set forth be this office and shall hereby agree to abide to all terms and conditions stated herein.**

_____ _____
Patient's Name (if minor, Responsible Party **Date**

Print Name_____