Authorization for Release of Information

(Entity of Person from whom records are requested) | **Address**

Telephone | **Fax** | **City** | **State** | **Zip**

I hereby authorize the above-named provider and or entity to disclose my individually identifiable health information as described below, which may include information concerning communicable disease such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), alcohol and or drug abuse, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my health care and payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive this information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

Patient Name (please print) | **Date of Birth** | **Social Security Number**

Patient Address (City, State and Zip) | **Patient Phone Number**

Specific Date(s) of Service (if known) | ☐ All Dates of Service

Information to be released: (Check all that apply)

☐ **Complete Medical Records** ☐ Radiology Reports & Films ☐ Registration Records
☐ Billing Records ☐ Visits & Encounters ☐ Laboratory Reports
☐ Consultation Reports ☐ Emergency Room Records ☐ Operative Records ☐ Other:_____

Purpose of release: ☐ Continued Care ☐ Transfer Legal ☐ Personal ☐ Other (please specify):_____

The health information described herein shall be **released to the following**:

Name of Person or Entity (please print) | **Phone Number**

Address (City, State and Zip) | **Fax Number**

Delivery Method: ☐ Mailing Address ☐ Fax ☐ Pick-Up Records ☐ Other:_____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep. I understand that there may be a fee for preparing and furnishing this information for my personal use.

Signature of Patient, Parent, or Legal Gaurdian | *Relationship to Patient* | *Date:*

Printed name of Patient, Parent, or Legal Gaurdian *or* *Legal Authority (Attach Supporting Documentation)*

Reclaim Internal Medicine
3900 S. Stonebridge Dr., Suite 1404 McKinney, Tx 75070 **Phone: 214-379-4234** **Fax: 214-453-2142**

HIPAA Notice

Standard Authorization of Use and Disclosure of Protected Health Information
Information to Be Used or Disclosed

The information covered by this authorization includes the following:

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by Reclaim Internal Medicine and/or Reclaim Physicians Medical Group.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and/or by contacting the office's Privacy Officer.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize Reclaim Internal Medicine to use my protected information for the listed reasons.

Approved HIPAA Contacts:

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the patient or legal guardian. If you would like to add additional contacts (other than the patient or legal guardian) that Reclaim Internal Medicine is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each individual listed. In addition, please choose the person you would like Reclaim Internal Medicine to list as your **Emergency Contact** in the event that an emergency situation was to take place in our office.

Contact Name	Relationship to Patient	Contact Number
☐ **Billing Account Information**	☐ **Medical Condition Information**	☐ **Emergency Contact**
Contact Name	Relationship to Patient	Contact Number
☐ **Billing Account Information**	☐ **Medical Condition Information**	☐ **Emergency Contact**

*** The duration of this authorization is one calendar year unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information. ***

Patient Name (Printed)

Patient Signature **Date**

Patient/Legal Guardian Signature

Patient Health History

RECLAIM INTERNAL MEDICINE

Name: _____ Gender: _____

Allergies: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____

_____ _____ _____

_____ _____ _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD/ Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	
Asthma	Glaucoma	Neuropathy	
Bipolar	Heart Disease	Osteopenia/Osteoporosis	
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer: _____	High Blood Pressure	Peptic Ulcer	
Headaches	Kidney Stones	Psoriasis	
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Last Menstrual Period	Date:	Normal Abnormal
Colonoscopy	Yes/No Date:___	Normal Abnormal
Mammogram	Yes/No Date:___	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:_	Normal Abnormal
Pap	Yes/No Date:___	Normal Abnormal

Other medical problems not listed above:

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____

_____ _____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

Continued on other side.

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type:_____Amount/day: _____ Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

SIBLINGS:

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature: _____ Date: _____

RECLAIM
INTERNAL MEDICINE

PATIENT INFO

Name:
(LAST) (MI) (FIRST)

Address:
(STREET) (CITY) (STATE) (ZIP)

Home Phone: Work Phone: Cell Phone:

Email Address:

Date of Birth: / /

Driver's License #: State:

Marital Status: S M W Spouse's Name:

Your Employer: Occupation:

Employer Address:
(STREET) (CITY) (STATE)

Referred By:

INSURANCE INFORMATION

Insurance Type: (Please Circle One) Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name:

Member #: Group #:

Insurer's Name (If Different From Patient): Relationship to Patient:

Insurer's DOB: / / Insurer's Soc. Sec #: - -

Insurer's Employer:

Person responsible for account:

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient/Guardian Signature: **Date:**

RECLAIM
INTERNAL MEDICINE

Patient Health History

Name: _____ Gender: _____

Allergies:_____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____
_____ _____ _____
_____ _____ _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADD/ADHD	Diverticulitis	Liver Disease	Stroke
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Lupus	Thyroid Disorder
Arthritis	Eczema	Macular Degeneration	Ulcerative Colitis
Alcoholism	GERD	Migraines	
Allergies, Seasonal	Glaucoma	Neuropathy	
Anxiety	Headaches	Obesity	
Arrhythmia (irregular heart beat)	Heart Attack (MI)	Osteopenia/Osteoporosis	
Bipolar	Heart Disease	Parkinson's Disease	
Bladder Problems / Incontinence	Hepatitis	Peptic Ulcer	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Diseas e	
Cancer: _____	High Blood Pressure	Psoriasis	
COPD/ Emphysema	High Cholesterol	Pulmonary Embolism (PE)	
Crohn's Disease	HIV	Reflux	
Dementia	Irritable Bowel Syndrome	Rheumatoid Arthritis	
Depression	Kidney Disease	Seizure Disorder	
Diabetes: Type I or Type II	Kidney Stones	Sleep Apnea	

Other Medical Problems NOT Listed Above:

_____

First Day of your last menstrual period: _____ Was is Normal or Abnormal? _____

Colonoscopy: Yes / No Date: _____ Normal / Abnormal

Mammogram: Yes / No Date: _____ Normal / Abnormal

Bone Density Scan: Yes / No Date:_____ Normal / Abnormal

Pap: Yes / No Date: _____ Normal / Abnormal

Surgical History: Please list all prior surgeries and approximate dates performed:

_____ _____
_____ _____

SOCIAL / CULTURAL HISTORY:

Are there any vision problems that affect your communication? ☐ Yes ☐ No
Are there any hearing problems that affect your communication? ☐ Yes ☐ No
Are there any limitations to understanding or following instructions (either written or verbal)? ☐ Yes ☐ No
Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter
☐ Skilled Nursing Facility ☐ Other: _____

Exercise: ☐Yes ☐ No How Often? _____

Smoking/Tobacco Use:
☐ Current ☐ Past ☐ Never Type:_____ Amount/day_____ Number of Years:_____

Alcohol: ☐ Current ☐ Past ☐ Never
Frequency: ☐ Socially _____ Per Day _____ Per Week _____ Per Month _____
Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____
Are you sexually active: ☐ Yes ☐ No
Are there any personal problems or concerns at home, work, or school you would like to discuss: ☐ Yes ☐ No
Are there any cultural or religious concerns you have related to our delivery of care? ☐ Yes ☐ No
Are there any financial issues that directly impact your ability to manage your health? ☐ Yes ☐ No
How often do you get the social and emotional support you need?
☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never
Comments (Please feel free to comment on any answers marked "yes" above):

Family History: (Please circle all that apply)

Father: Living Age:_____ Deceased Age: _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

Mother: Living Age:_____ Deceased Age: _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

Siblings: Living Age:_____ Deceased Age: _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

Grandparents:

_____

Please list any other medical providers that you see on a regular basis (i.e. Cardiologist, Mental Health, Kidney Doctor, Dentist, Etc.):

_____

_____

Patient Signature: _____ **Date:** _____

Insurance Verification Disclosure/Agreement

As a courtesy, Reclaim Internal Medicine & Reclaim Physicians Medical will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Assignment of Benefits

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, grants and conveys for deferred payment to Reclaim Physicians Medical Group, a lien and assignment against the proceeds of the patient's insurance settlement with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Reclaim Physicians Medical Group, and to 913 S. Main St., Unit 212, Grapevine, TX 76051.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Functional Medicine of Irving, and to send any and all checks to 913 S. Main St., Unit 212, Grapevine, TX 76051

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

By my signature be it known that I have read and fully understand the above contract.

Patient Name (Printed) _____Date _____

Patient Signature _____

Parent/Guardian Signature _____

Dear Patient:

This office has joined Reclaim Physicians Medical Group, Inc., which is a multidisciplinary doctor group. We have done this for various reasons, with the most important one being that our facility can enjoy a more comprehensive approach to your health by utilizing an integrative health care model. This means the incorporation of Medical and Osteopathic physicians, who are directly involved in your healthcare, into our scope of various services. As such, certain services and diagnostics will be administered, when clinically warranted, and billed under the Reclaim Physicians Medical Group, Inc. As such, when you receive your explanation of benefits from your health insurance company, it will indicate the date of services and procedure codes and payments made to Reclaim Physicians Medical Group, Inc. If you have any questions regarding this exciting amendment to our office, please ask me.

Sincerely,

Reclaim Internal Medicine, Dr. Mandy Thompson

FINANCIAL POLICY

Please initial next to each section indicating your acknowledgement then sign and date the bottom:

_____All current balances, co-payments, co-insurance and deductibles are **due and payable PRIOR to services** being rendered and is required by your insurance to be paid at each visit. We accept cash, check, VISA, MasterCard, Discover, and American Express. We do not accept post-dated checks.

_____REFERRALS: If you have a managed care plan, an HMO, or similar plan that requires a referral, you will need a referral from your primary care physician to see our providers. If your insurance requires a referral that is generated through them, you must reach out to your primary care office for them to call your insurance. It is not our policy to generate a referral for ourselves. **If we have not received this referral prior to your arrival at our office, your appointment will either be rescheduled or you may be responsible for the entire bill. It is your responsibility to know if a referral is required and to obtain one.**

_____INSURANCE BENEFITS: Please be aware that when a patient requires a visit to a health care provider, there are diagnostic tests or procedures that may be suggested for appropriate care that may be done by one of our providers. These procedures may be done during the normal course of the exam by specialized personnel. Although necessary as part of routine evaluations, insurance companies often categorize these as procedures. The possible procedures which often are performed in this practice during your visit include, **but are not limited to**:

Trigger Point Injections	B-12 Injections
Autonomic Nervous System Tests	NCV/EMG tests
US guided Injections	Doppler Studies
EKG Evaluations	Joint Injections
PRP/Amnio therapies	Physical Rehabilitation/PT

Depending on your insurance policy provisions, these procedures and others may fall under a separate benefit other than your office co-pay, such as a deductible or coinsurance. In most cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Therefore, any estimate for services will be considered an estimate only and any payment will be considered a partial-payment only until such time that the insurance company processes your claim. Your insurance is a contract between you and your insurance carrier; payment for services is ultimately your responsibility. It is extremely important for you to know your coverage. Many of the diagnostic and therapeutic procedures performed in our office (such as those listed above and others) are considered additional costs by your insurance company. Your health care providers are not aware of what additional costs may be incurred and will not review that with you. As health care providers, our physicians may recommend a diagnostic or therapeutic procedure available only to specialist physicians in order to provide you with the best possible treatment. If you have concerns regarding the cost of any procedure, you may ask your doctor if you can discuss the cost with our business staff BEFORE the procedure is performed to decide if you would like to have it done.

_____WAIVER OF CONFIDENTIALITY: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment and the type of treatment received at our office may become a matter of public record or disclosed to third parties.

_____ DIVORCE: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible to us for those subsequent charges.

_____ TRANSFERRING OF RECORDS: You will need to request in writing, and pay a reasonable copying fee (currently $25) PRIOR to sending copies of your records to another doctor or organization. You authorize us to include all

relevant information, including your payment history and hereby indemnify and hold us harmless for any claims or damages resulting from our providing records pursuant to your request. If you request records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

_____ **PERSONAL INJURY:** If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. Payment of the bill remains the patient's responsibility.

_____ **LIABILITY:** If you are being treated for a 3rd party liability claim and do not have an attorney, we will require that you allow us to bill your health insurance or file on your Personal Injury Protection. Upon settlement of your claim, YOU WILL BE RESPONSIBLE FOR ANY BALANCE OWED ON YOUR ACCOUNT REGARDLESS OF THE AMOUNT OF SETTLEMENT YOU RECEIVE FROM THE INSURANCE COMPANY. Please understand upon settlement of your claim, the 3rd party carrier will NOT PAY US DIRECTLY; however, you remain fully responsible for payment of your account. If you do not have health insurance or PIP, we must have a letter of protection on file from an attorney. Otherwise, you will be responsible for payment in full at the time services are rendered. We have the right, at our sole discretion, to refuse to accept a letter of protection for payment of your services.

_____ **FORMS FEE:** Please allow 5-7 business days to complete all forms that require a physician signature and medical review (i.e., Worker's Comp, FMLA, Short-term disability (STD), other extended leave of absence, etc.) The physician must take the time to fill out the forms and as such may charge for each record requested, a $30.00 Forms Fee. Each time a correction needs to be made to a form, another Forms Fee will be charged to the account. There is no exception to this rule. Additional medical records request will also have a $40.00 assigned fee.

_____ **NO SHOW/CANCELLATION COURTESY:** We are committed to making you an appointment at your earliest convenience; likewise, we require a call at least 24 hours in advance if you are unable to keep your appointment to allow for other patients to be seen. If you "no show" for an appointment or cancel with less than 24 hours' notice, you will be charged a $25.00 fee. Multiple missed appointments may result in our request for you to find another provider.

_____ **RETURNED CHECK FEE:** There is a $35.00 fee for checks returned for any reason and will be added to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

_____ **PATIENT BALANCE POLICY:** After filing with the insurance company, we will promptly mail you a patient statement. Payment in full is due upon receipt of this statement and is a courtesy from our office. If you have any questions or dispute the balance, it is your responsibility to contact our billing office within 30 days. Accounts past 30 days will be considered past due and may be referred to outside resources for further management. If you are unable to pay the balance due in full, you must contact our billing office to discuss a payment schedule or arrangements. Any late fees incurred on past due balances will be included in any mutually agreed upon arrangements.

_____ **BANKRUPTCY:** If we attempt to collect a debt and you have filed for bankruptcy, and we are listed as a creditor, please advise us of this and we will cease collection activity immediately.

Patient Name: _____Date: _____

Parent/Guardian Name: _____

Patient Signature: _____ (Parent/Guardian if minor)