**Patient Consent**

**Consent for treatment:**

I hereby authorize the performance of any medical procedure which may be advised and/or recommended by Dr. Bernice R. Swain while I am under her care.

**Authorization for release of medical information:**

I authorize Dr. Bernice R. Swain and/or authorized employee to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment for my care

**Financial Policy:**

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees. Financial Policy, or your responsibility. All patients must complete our *"Patient Information form"* Before receiving treatment.

I understand that I will be responsible for all charges incurred during my course of treatment in this office regardless of insurance coverage.

Adult patients: Are responsible for full payment.

Minors Accompanied by an Adult: The adult accompanying a minor, and his/her parents (or Guardian), are responsible for full payment.

Unaccompanied Minors: The parents (or guardians) are responsible for full payment. Non-emergency treatment may be denied unless charges have been pre-authorized to an approved method of payment (cash, or check).

**Insurance:**

If you have insurance, we will help you receive maximum benefits. If we accept your insurance, you will be responsible for your estimated co-payment amount and any unmet deductible at the time of service.

**Insurance is a contract between you and your insurance company.**

We are NOT a party to this contract. We file insurance claims as a COURTESY to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual, customary & reasonable" charges, etc. other than to supply factual information as necessary. You are responsible for the timely payment of your account.

Any account that we receive no payment on for 90 days will be turned over to a collection agency for collection. At that time, you will be responsible (or the balance on your account, and an additional charge of 40% of your total balance to cover the collection agency fees. Therefore, please do not let your account reach this point without trying to make satisfactory arrangements with us to keep your account current.

**Missed Appointments**

If you cannot make your appointment, please call at least two hours in advance to cancel. We reserve the right to charge for any non-cancelled appointment. It is our policy that three consecutive ''NO SHOW” for two scheduled appointments, or a total of six cancellations and/or no shows constitute discontinuation of treatment.

Patient (Responsible Party) Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_