Name:_____

Date of Birth:_____

Any changes to address or telephone numbers?

_____

_____

_____

_____

Any changes to medications that were listed from last visit?

_____

_____

_____

_____

_____

Our office is doing everything possible to maximize the efficiency and minimize the cost of your healthcare. It is a courtesy to our patients that we file your insurance. In order to accomplish this please have all your insurance cards present. Due to co-pays, deductibles, or non-covered procedures or products, your insurance may reject some or all of the billed charges. **CO-PAYS ARE DUE AT TIME OF SERVICE.** Should it become necessary to bill you for the services rendered, a $10.00 billing fee along with a monthly finance charge will be added to your account.

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt, and agree to pay said fee, including any/all costs of collection, attorney fees and /or court costs, if such necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state.

Date:_____

Print Name:_____

Signature:_____

Relationship to patient:_____