ACKNOWLEDGEMENT OF RECEIPT OF POLICIES

1. AUTHORIZATION TO PAY BENEFITS AND RELEASE INFORMATION

I hereby authorize my insurance to make payment directly to Diabetes Management Associates for medical services rendered. I give authorization to release medical information obtained during the course of my treatment to my insurance company for the purpose of obtaining payment. I understand that all the charges incurred are my responsibility, regardless of insurance coverage or third party liability. In the event my account is placed with an attorney or third party agency for collections, I agree to pay all reasonable court costs and collection fees. I understand that all judgments in a court of law may bear interest at the legal rate.

2. PATIENT INFORMATION

3. FINANCIAL POLICY

4. NOTICE OF PRIVACY PRACTICES

Your signature verifies that you:

- have read the above named policies/disclosure statement and understand your responsibilities
- accept full responsibility
- agree to these terms.

Patient Name (printed): ____ DOB: _______________________

Signature of Patient (or Responsible Party): ____

Date: ________________________