Financial Agreement

As a courtesy, **DOCTORS OSTEOPATHIC** will contact your insurance company for a verification of benefits. All patients are encouraged to call their insurance company for further verification or clarification of benefits**. DOCTORS OSTEOPATHIC** will not be held responsible for mis-information obtained during the verification process. In most cases, **DOCTORS OSTEOPATHIC** will bill your insurance. However, any account balance incurred with **DOCTORS OSTEOPATHIC** is legally the responsibility of the patient. The adult, parent or legal guardian, accompanying a minor, is responsible financially for all services provided by **DOCTORS OSTEOPATHIC** and agrees to all terms listed in this agreement.

TERMS OF AGREEMENT

- **DOCTORS OSTEOPATHIC** requires a 24 hour notification on all cancellations. Missed appointments and late cancellations will result in a **$25.00 charge** to the patient.
- I have reviewed my insurance benefits with an **DOCTORS OSTEOPATHIC** representative, (as provided by your insurance company), and have been notified of any co-pays, co-insurances or deductibles.
- All co-pays, co-insurances and deductibles, are due prior to each treatment.
- Verification of Benefits is not a guarantee of payment by the insurance company and I am responsible for any dates of service or procedures not covered by my insurance plan.
- I will notify an **DOCTORS OSTEOPATHIC** representative of any changes in my information, including but not limited to address, phone number or insurance coverage.
- I, the undersigned, certify that I (or my dependent) have insurance coverage as provided to **DOCTORS OSTEOPATHIC** and assign directly to **DOCTORS OSTEOPATHIC** all insurance benefits, if any, otherwise payable to me for services rendered.
- **DOCTORS OSTEOPATHIC charges a $25.00 fee** for the **completion of all forms** not related to routine treatment of a patient.
- I understand that I am financially responsible for all charges whether or not paid by the insurance.
- I hereby authorize the release of all information necessary to secure the payment of benefits.
- I authorize the use of this signature on all insurance submissions.

_____/_____ _____--_____--_____

Patient Signature (or responsible party) Date Social Security Number

Consent for the Use and Disclosure of Protected Health Information

By signing below, you consent to the use and disclosure of your protected health information by DOCTORS OSTEOPATHIC, Dr. James Milne, our staff, and our business associated\s for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised version by simply contacting DOCTORS OSTEOPATHIC, Dr. James Milne, 954-776-7566 and requesting a revised Notice. We will also post any revised notice in this facility. You have the right to request that we restrict our uses or disclosures of your protected health information which we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

_____ _____

Signature Date

- **Please give name(s) of person(s) that may obtain verbal information regarding your medical history:**

Name_____ relation_____

Name_____ relation_____

Consent for Care and Treatment

I understand my right to participate in my treatment process. I am mentally competent and do hereby consent to necessary examination, procedures, and/or treatments prescribed by my physician, his assistants or designees as is necessary in his/her judgment.

_____ _____

Patient/Guardian Signature Date