The Office of Dr. Andres Patron appreciates the confidence you have shown in choosing us to provide for your health care needs.

I _____ hereby authorize and consent Dr. Andres Patron, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment(s),medical testing and treatment procedures.

Furthermore, the service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. I understand that I am financially responsible to Dr. Andres Patron for Charges which the carrier declines to pay. It is further agreed that any credit balance resulting from the payment by my insurance or other sources may be applied to any other accounts owed to Dr. Patron by the insured.

I the patient in turn, authorize Dr. Andres Patron and any others acting in my behalf, to submit information as required or requested by my insurance carrier to process my medical claims, and assign benefits. Hence, if my INSURANCE CARRIER is unresponsive, I will be billed directly since I understand that I am ultimately responsible for payment of my bill and or any services not covered by my insurance carrier(s) and or Medicare. In addition I understand my responsibility to meet any applicable yearly deductible(s), co-payment(s) and co-insurance(s).

All patient balances, as determined by your insurance company are due and payable within 30 days of invoice. Interest will be accrued for balances over 30 days at 18% annual percentage rate and a collection fee added to balances over 90 days.

I also understand and agree to pay the legal allowable interest rate, collections fees, and or legal fees if my account becomes delinquent at any time and by my Signature, offer guarantee of payment to the doctor's office in full. Any fees incurred to enforce payment required by this agreement will be paid by the delinquent client, and any information necessary to collect said debt will be released for that purpose to the doctor's agent.

The Patient (guardian/guarantor) agrees to be fully responsible for total payment(s) of procedure(s) performed in this office, including any treatment that is not a benefit of any medical insurance the patient may have.

I have read and understand the above information, and I agree to the terms described:

Patient / Guarantor Signature: _____ Date_____