PAYMENT FOR SERVICES RENDERED

I HEREBY AUTHORIZE AND GUARANTEE PAYMENT FOR ALL SERVICES RENDERED.

Although fees for services are due and payment expected at the time services are rendered, if I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received.

☐ *If patient is a Medicare Recipient:*
I request payment under the Medicare Program to be made directly to this doctor on my behalf. I agree to pay any balance due which Medicare does not or will not pay, including but not limited to co-insurance, annual deductible, services not covered or rejected for any reason. I understand the total amount due is my responsibility until the total amount due is satisfied.

☐ *If the patient is a Medicaid Recipient:*
I request that payment for all services are made directly to this doctor on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized agents any information needed for this or any related claim. I also agree to pay any amount Medicaid did not or will not pay because I was ineligible to receive Medicaid Benefits or services were outside of program limitations.

☐ *If the patient is covered by Health Insurance:*
I request all payments be made to this doctor directly for covered services. I agree to pay any amount the insurance company did not or will not pay.

In the event that my account becomes delinquent for more than 120 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as all collection costs, court costs, attorney fees and interest fees accrued with the collection of this account.

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Responsible Party **Date**