PAYMENT POLICY

ALL PATIENTS ARE RESPONSIBLE FOR FULL PAYMENT OF THEIR ACCOUNT(S) AT THE TIME SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS ARE APPROVED.

Gonzalez and Carr P.C. accepts insurance payments on behalf of the patients receiving treatment; however; the payment for services rendered to an insured patient is the responsibility of the patient, not the insurance company.

As a courtesy to our patients, we will be happy to assist in completing insurance forms relative to treatment, however, since our professional services are rendered to you, not the insurance provider, you are directly responsible to us for your financial obligations. Gonzalez and Carr P.C. does not accept responsibility for collection of patient insurance claims.

OVERDUE ACCOUNTS

"The patient and the responsible party hereby acknowledge their understanding that the payment is due in full upon receipt of the invoice statement, and agree to pay a one and one-half (1-1/2%) percent late charge on all accounts over 90 days past due. The patient and responsible party further agree that failure to make payment when due can result in the account being turned over and agree to pay any and all costs of collection, including a reasonable attorney's fee. The patient and responsible party to further secure any outstanding balance agree to waive all claim of exemption of personal property under the State of Alabama and the Constitution of the United States. The patient and responsible party agree that their obligations are joint and severable and that Gonzalez and Carr P.C. may pursue either or both parties for payment."

I understand and authorize all dishonored checks plus a processing fee with applicable taxes to be electronically debited from my account.

DL # _____ PATIENT SIGNATURE **X** _____

DATE _____ SIGNATURE _____
(State relationship if other than patient)

RELEASE OF INFORMATION

The undersigned hereby authorizes said Gonzalez and Carr P.C. to release any and all medical/dental information to his or their insurance company(s) or other physicians or hospitals involved in the treatment of said patient.

SIGNATURE **X** _____
(State relationship if other than patient)

ASSIGNMENTS OF BENEFITS

I, the undersigned, hereby authorize payment directly to Gonzalez and Carr P.C.

DATE _____ PATIENT SIGNATURE **X** _____

SIGNATURE _____
(State relationship if other than patient)

• POLICY/RELEASE/ASSIGNMENT
(To Be Filled Out By Patient)