



I agree to pay for all services rendered. I agree to pay any and all amounts that my insurance company applies to any unmet deductible. If my insurance company requires a co-payment, I agree to pay it at the time of each appointment. If my insurance pays on a percentage basis, I agree to pay an average amount per visit based on what my percentage is. This is to be negotiated and agreed upon with the office manager.

I understand that I will be fully responsible for any services deemed as non-covered or denied by my insurance company. I agree to pay for any medical supplies that are not covered by my insurance, under my policy. I recognize and accept complete financial responsibility for any balance remaining after the payment of correct benefits by an insurance company.

If my insurance company is out-of-network with Goddard Orthopedic and there is a limit on the number of units per visit, I agree to pay the difference between what is paid by my insurance company and the services rendered by Goddard Orthopedic.

I assign insurance benefits for all services rendered by permitting payment directly to Goddard Orthopedic & Sports Therapy, Inc. for services rendered.

Payment can be made in the form of cash, check, and/or credit card (Visa or MasterCard). There will be a \$25.00 per check charge for all returned checks.

We ask to keep your credit card number or Health Savings Account number on file to guarantee appointment attendance, co-pays, and deductibles. Your credit card will be automatically charged for the balance of any outstanding accounts (including service charges, co-pays, and deductibles) that are delinquent beyond 60 days.

VS or MC Name on Card: _____

Card #: _____ **Exp. Date:** _____

I certify that I am 18 years of age and/or the legal guardian/guarantor. I understand and accept full financial responsibility for the patient listed below.

Printed Name of Patient: _____ **Date:** _____

Signature of Patient and/or Legal Guardian: _____