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Financial Acknowledgement

Name (Please print)

Today's Date

Date of Birth

SSN

I am stating that I am a self-pay patient and I do not have health insurance and/or government issued health insurance assistance (such as Medicaid, Caresource, Molina, etc.). I will notify the practice immediately should I acquire insurance. I understand that if I provide false information, my dependants and I will be discharged from the practice.

I understand that if I am seeing a provider (physician/nurse practitioner), \$50.00 will be collected on today's visit, if I am seeing a nurse \$25 will be collected. There will be a 10% discount applied to the total bill, and the patient will be sent a statement for any remaining balance.

Signature

Date

I have health insurance but do not have my card with me. I understand I will be financially responsible for all charges on today's visit unless I present my insurance card within 30 days of today's visit.

Signature

Date