Financial Agreement

I acknowledge full responsibility for the payment of services and agree to pay for them at the time of service, unless other arrangements have been made. I authorize the release of my medical or other information necessary to process insurance claims and understand that I am responsible for all charges, regardless of insurance. I also authorize the release of my medical records to other physicians I am seeing. I authorize payment of medical benefits to Asheville Endocrinology, P.A. for services provided for which I have not paid. If I have government benefits I request payment to myself or to Asheville Endocrinology, P.A., if assignment is accepted.

Printed Name: _____ DOB: _____

Signature: _____ Date: _____