FINANCIAL RESPONSIBILITY

I have requested medical services from Rindfleisch Family Practice on behalf of myself and/or my dependents, and understand that by making this request, I am financially responsible for all the charges incurred in the course of treatment.

I further understand that fees are due on the date that services are provided, and I agree to pay all such charges.

I hereby assign all insurance benefits from which I am entitled to Rindfleisch Family Practice and authorize my insurance carrier(s), including Medicare, Medicaid, private insurance and other health/medical plans, to issue payment directly to Rindfleisch Family Practice for medical services provided to myself and/or my dependents. **I understand that I am responsible for any amount not covered by insurance including deductibles, co-pays, or other services or items not covered by my insurance plan(s).**

I understand that there will be a $20 fee for all missed appointments, or cancelled appointments without a 24 hour notice.

Patient/Responsible Party Signature _____

Print name _____Date_____