Name: _____ DOB: _____ Rec No: _____

Provider: Peter B. van Dyck, M.D.

Receipt of Notices and Request for Services

_____ I have read the attached Professional Disclosure Statement for Peter B. van Dyck, M.D., an employee of Peter B. van Dyck, M.D. & Associates, P.A.

_____ I acknowledge receipt of a copy of the Notice of Privacy Practices.

_____ I hereby request professional services from this professional. I understand the first one to two visits are for evaluation purposes and are not a guarantee of further treatment. If ongoing treatment at this office is indicated and mutually agreeable then a treatment plan will be agreed upon at the end of the evaluation.

Financial Responsibility

_____ I hereby unconditionally guarantee payment to Peter B. van Dyck, M.D. & Associates, P.A for all costs, charges and expenses incurred by said patient at this office, unless separate arrangements are agreed upon in writing.

I also agree to pay a service charge of $25.00 for any checks that are returned unpaid. I understand if the patient balance for services provided is not paid within thirty days of billing date, the amount due will be deemed delinquent. In the event the account is turned over to a collection agency, I agree to pay a $10.00 collection fee will be added to the existing balance. In the event legal action should become necessary to collect an unpaid balance due for services rendered to said patient, I agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

Insurance/Managed Care/Third Party Payment

_____ I understand it is my responsibility to inform the office of any changes in my insurance, prior to the effective date of the change and accept financial responsibility for any office charges that were incurred prior to this date.

_____ If I have third-party reimbursement, I understand it is only for the services they have agreed to cover. I understand that any additional services I desire are being provided outside this insurance arrangement, and I accept full financial responsibility for these services.

_____ I certify the following information to be accurate:

❑ **No Third Party Payer**. I have no insurance, or request that no insurance claims be filed by the office. I will accept full financial responsibility for any services the office provides.

❑ **Insurance/Third Party Coverage, But No Contract**. I have insurance/third party coverage with: _____. I understand there is not a contract between this payor and the office for this provider's services. I accept financial responsibility for my bill regardless of whatever action my insurer takes. I request that claims be filed with this carrier and authorize the office to provide whatever medical information is required by the carrier for the processing of the claim. I also assign benefits directly to the office.

❑ **Contract with Insurance/Third Party**. I have insurance/third party coverage with: _____. I understand there is a contract between this payor and the office for this provider's services. I accept responsibility for any deductibles and co-payments specified by this contract. I request that claims be filed with this carrier and authorize the office to provide whatever medical information is required by the carrier for the processing of the claim. I also assign benefits directly to the office. I accept financial responsibility for any services I desire that are not covered by my insurer

_____ _____
Patient Date

_____ _____
Legally Responsible Person Date

_____ _____
Provider Date