Karle Medical Group, P.C.
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Office Visit Expenses for Self-Pay Patients

Notice of Responsibility

Patient First and Last Name: _____ Patient Date of Birth: _____

Today's Date: _____ Visit Provider: _____

Payment Due Terms

- Any patient over the age of 18, or emancipated minor, will be held financially responsible for all charges. If another party is responsible for payment of your account, you must pay your balance in full and negotiate repayment with them outside of our office. This includes individuals negotiating divorce agreements.

- Our office policy also states that **payment is due at time of service**, we accept cash, check and credit card. Failure to comply with our office protocol will result in an increase of 20% and a late charge of $25. Additionally, the Karle Medical Group is not responsible for any fees or expenses associated with laboratory testing submitted to outside entities. Furthermore, any fees or expenses associated with medical care received as a consequence of instruction from a Karle Medical Group provider are wholly the patient'

By signing this form, I acknowledge that I have read this patient information sheet and acknowledge that the requirement of this form and my acceptance of responsibility for the office visit charges is standard practice for me in cases such as this.

_____

Patient Signature Date