I understand that I am financially responsible for the services that I receive.

Payment is expected at the time of service unless prior arrangements have been made. I understand that there will be a **$35.00 NSF fee** for any Returned checks.

Signature ____________________ Date: __________

FOR PATIENTS WITH INSURANCE COVERAGE, PLEASE READ AND SIGN:

I authorize the release of any medical information and request that benefits be paid directly to Beaumont Foot Specialist for services rendered. I understand that Dr.Bruyn is filing my claim as a courtesy and that this does not relieve me of financial responsibility of Non-covered services or supplies.

Signature ____________________ Date: __________

ACHKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that the Notice Of Privacy Practices was available and that I have read (or had the opportunity to read if I choose) and understand the notice.

Patient Name ____________________

Signature ____________________ Date: __________