Patient: _____
Date: _____

PATIENT RESPONSIBILITY AGREEMENT

I hereby give permission to **Womick Podiatry Clinic, P.C.**, to examine, diagnose and treat my feet and ankles medically, and/or surgically. I accept full responsibility for any charges rendered to the above named patient. Payment is due for services when rendered unless other arrangements have been made in advance in writing. I understand that I am responsible for all deductibles, co-payments and non-covered service charges. **Patients are responsible for obtaining and monitoring their own referrals.** Cancellations must be made 24 hours in advance in order to avoid being charged. Insurance cannot be billed for missed appointments. Payments not made when due, will bear interest at the rate of 1.83% per month (22% per annum A.P.R.) and the responsible party will be liable for all reasonable **costs of collection including attorneys fees** of the unpaid balance.

I hereby authorize the above physician(s) to release any information regarding services by him/her, and allow a photocopy of my signature to be used to file insurance. I also authorize payment of medical benefits to **Womick Podiatry Clinic, P.C.** I understand that **Womick Podiatry Clinic, P.C.** may file some types of insurance as a courtesy to me, but **I am responsible for staying in contact with my insurance company to see that it makes payment to Womick Podiatry Clinic, P.C. in a timely manner.** In the event that my insurance company pays none or only a portion of **Womick Podiatry Clinic, P.C.** bill, I will be responsible for the remaining balance. Any balances that are **unpaid after 60 days** from the date of service will be considered delinquent, and will be reported to a collections attorney. Your account may also be reported to a consumer credit reporting agency.

Patient's Name_____ **Signature**_____
Please Print (RESPONSIBLE PARTY) Please sign