Honeygo Podiatry
Edward S. Orman, D.P.M., P.A.
Board Certified, American Board of Podiatric Surgery

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PATIENT'S FINANCIAL RESPONSIBILITY

I assume full responsibility for payment of charges, even if insurance is involved and the carrier fails to pay. I realize that I am responsible for all charges (this includes deductibles and co-pay amounts). I acknowledge that if I fail to make payment; my account will be turned over to our attorney for collection. In that case, I will be obligated to pay all cost of collections; which include but are not limited to attorney's fees of 33 1/3% of all unpaid balances when the account is placed with our attorney. These fees are in addition to the balance owed to Dr. Edward S. Orman. Additionally, I will be assessed a $5.00 rebilling fee on all unpaid balances every 30 days. Also, I am fully aware that all returned checks are subject to a $25.00 returned check fee.

I hereby agree to waive the defense of the Statute of Limitations as it pertains to any claim filed against me beyond three years (or other statutory period) after services rendered.

By signing below, my signature is on file and I acknowledge that I have read and understood this form And acknowledge the terms and conditions stated herein.

______________________________ **Date**

______________________________ **Patient's Name (Please Print)**

______________________________ **Parent or Authorized Representative (if applicable)**

______________________________ **Signature**