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 **necessarily** limited to attorney's fees of 33 1/3% on all unpaid balances, **court filing fees, and private process server fees."** These fees are in addition to the balance owed to Dr. Edward S. Orman. 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 Limitation; 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 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**