DEBORAH WESTERGAARD M.D.

9301 N. Central Expy, Suite 115, Dallas, Texas 75231 ph. 214 750 6200

Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

The office of Deborah Westergaard,, MD, PA, appreciates the confidence you have shown in choosing us to provide for your health care needs. The services you have elected to participate in impliesy a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment for your bill.

You are responsible for payment of any deductible and co-payments/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Dr. Deborah Westergaard's office, for pain management services rendered to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Deborah Westergaard, MD, PA, the full and entire amount of the bill incurred by me or the above named patient; or, if applicable, any amount due after payment has been made by my insurance carrier.

Signature of Patient / Guarantor: _____ Date: _____

Co-Pay Policy

Some health carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the services are rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Signature of Patient / Guarantor: _____ Date: _____

Consent for Treatment and Authorization to Release Information

I hereby authorize Deborah Westergaard, MD, PA through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Deborah Westergaard, MD, PA to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment. Other than the Physician's office that referred me, my primary Care Physician, and any Physicians or facilities that I am referred to by Deborah Westergaard, MD, PA, the following people are allowed to receive a copy of my records, or speak to the appropriate staff in Dr Deborah Westergaard's office regarding my treatments.

1. _____ 2. _____ 3. _____

Signature of Patient / Guarantor: _____ Date: _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, I may be charged a $25.00 fee. This fee will not be paid by insurance, this is the patient's responsibility and will be collected prior to seeing the physician.

Signature of Patient / Guarantor: _____ Date: _____

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Deborah Westergaard, MD, PA. I agree to pay Deborah Westergaard MD, PA, the full and entire amount of treatment given to me or to the above named patient at each visit.

Signature of Patient / Guarantor: _____ Date: _____