FINANCIALRESPONSIBILITY
AGREEMENT TO PAY

Patient Name:_____

I accept FULL FINANCIAL responsibility form Astar Medical Group. Should my insurance company deny a pay for a portion of a visit, I understand that I will be required to pay for these services IN FULL.

Patient or legally authorized Representative signature:

Signature:_____Date:_____

I certify that I am the legal Guardian, POA or responsible party for the above named patient.

Signature:_____

Acknowledgement of Receipt of Privacy Practices Statement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Mr._____ at 305-_____.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Signature:_____Date:_____

Printed Name:_____ Relationship:_____