

Patient Acknowledgement of Responsibility

Assignment and Release

I, the undersigned certify that I (or my dependent(s)) have coverage with _____ and assign payments directly to Dr. Wein M.D. P.A. ,for any and all treatment rendered through the duration of my treatment plan, otherwise payable to me for services rendered. **I understand and accept full financial responsibility for all charges, whether or not paid by my insurance.** I authorize the use of this signature on all insurance submissions.

_____ Responsible party Sign	Relationship	Date
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Notice of Privacy Practice

I, the undersigned acknowledge I can/will be given a copy of the Privacy Practice of this office, as required by law. This states that this office will not give forth any given or collected information from any patient of this office without written consent.

_____ Responsible Party Sign	Relationship	Date
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Immunotherapy Financial Consent

In the Event that I, the undersigned give my consent for the Office of Dr. Michael Wein, M.D. P.A to begin Immunotherapy Treatment, **it will be my full financial responsibility, whether the insurance covers the antigen specifically made for me or if it's applied to my patient responsibility.**

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Collection Policy/ Insufficient funds

I, the undersigned am advised that effective January 1, 2005 any account that becomes delinquent and is turned over to MCB collections may be applicable to a service charge of 25% of the delinquent balance.

I, the undersigned am advised that effective January 1, 2010 any payment that is received and then returned for insufficient funds will be responsible for any service charges rendered.

Responsible Party Sign

Relationship

Date

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