STATEMENT OF FINANCIAL RESPONSIBILITY

ALAMO MEDICAL CLINIC

A. I hereby apply for treatment by the above facility. Such treatment is to include all office procedures as necessary.

B. I, _____ (patients name), accept responsibility to pay for all services rendered on my behalf.

C. In the event of default on any payments due to Alamo Medical Clinic, I agree to pay all costs of collection including attorney's fees.

D. Pursuant to NRS 629 my health care records may be destroyed after 5 years.

INSURANCE ASSIGNMENT

A. This will authorize the filing of any insurance in force and the direct payment to Alamo Medical Clinic, of any amounts due on my claim under the above stated policy (policies).

B. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to Alamo Medical Clinic for any fees not covered by insurance.

C. I hereby authorize Alamo Medical Clinic to release any information acquired in the course of examination or treatment to:

_____
(NAME OF INSURANCE COMPANY OR OTHER PARTY)

I agree to all of the above and acknowledge receipt of this agreement.

Signature of Patient _____ Date _____

Witness _____

Please notify receptionist if you have any Primary/Secondary or Supplement affiliated with **HPN / HMO / FHP / HUMANA / SENIOR DIMENSIONS / SENIOR HORIZONS**