Financial Policy Agreement:

I have read and fully understand the practice financial policy. I agree to pay all costs of collection including collection agency fees, attorney fees and costs incurred by the practice in collecting for services rendered. Intending that you shall rely on my statement herein, I certify to you the foregoing information is true and complete. I have read and hereby agree to be bound by the terms of this agreement as set forth. The signature(s) below are valid until revoked by me, in writing.

____
Patient Name (Please print name in full)

____ ____________
Patient Signature (or parent or guardian) Date

Authorization to Release Information:

I authorize David Ascher and the qualified employees of the practice to release any information regarding the medical history and treatment including disability related information to any 3rd party payer, or their contracted agents to validate or determine benefits payable for services rendered to myself or any dependants.

____
Patient Name (Please print name in full)

____ ____________
Patient Signature (or parent or guardian) Date