Rev 11/1/11

COLLINS MEDICAL
ASSOCIATES 2, P.C.

A Saint Francis *Care* Provider

PAYMENT POLICY ACKNOWLEDGMENT FORM

I am a patient of Collins Medical Associates 2, P.C. I hereby acknowledge that I have read and understand the payment policy of Collins Medical Associates 2, P.C. and agree to abide by its guidelines.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge that I have read and understand the payment policy of Collins Medical Associates 2, P.C. and agree to abide by its guidelines.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____