

Drs. Branton & Jarrah, P.A.

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Financial Responsibility Statement

(Signing this document will affect your rights under Maryland law. Please read carefully before signing this document.)

I, _____, (patient name) am seeking medical attention from Drs. Branton & Jarrah, PA.

I understand the practice is Fee-For-Service and I am required to pay the balance in full at the time of the visit. The practice will submit charges on my behalf to my insurance carrier. The practice is not responsible for reimbursement from my insurance carrier. I understand, reimbursement, if any, will be based on my insurer's fee schedule and if the service is a covered necessity. In the case of an HMO, I understand that I may not be entitled to reimbursement.

Appointments: Once an appointment is made, please remember this time has been reserved for you. A minimal charge will be made for failed or cancelled appointments without prior 24-hour notification. This fee covers only a portion of the overhead costs such as salaries, electricity, heat, rent, etc., which still must be paid whether you are present or not.

The undersigned promises to pay all cost of collections equal to 35%, including, but not limited to court costs and attorney's fees equal to 15% of any amount due.

(Patient Signature)

(Date)