Ronald L. Renard, MD
1505 Victor Avenue
Redding, CA 96003

STATEMENT OF FINANCIAL RESPONSIBILITY

It is the policy of this practice to collect payment for services as they are rendered. This allows us to control our costs and to keep fees at a reasonable level.

This office bills *most* insurance companies; however these services cannot be rendered on the assumption that your charges will be paid by your insurance company. It is important that you are aware of the extent of your insurance coverage. Your insurance is a contract between *you* and *your* insurance carrier; the responsibility for the full charges for your medical care ***is yours.***

Patients with co-pays and deductibles are responsible for them ***at the time of service.*** There will be NO exceptions. Our contract with your insurance requires co-pays to be collected at the time of service and you will be asked for your co-pay at ***every*** visit to this office.

I, the undersigned, have read the above statement, and accept full financial responsibility for all medical charges incurred by me, or my dependents, for services rendered by Ronald L. Renard, MD.

_____

Patient's Name Date

_____

Signed By Relationship to the patient

_____

Witnessed By Date