ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I acknowledge my financial responsibility to pay for all services received from *Affinity Myo, LLC*, regardless of insurance coverage or eligibility and that **payment is due at the time of services rendered** unless other arrangements have been made.

Initial ____

I authorize the release of any medical information necessary to process my insurance claim(s) and assign *Affinity Myo, LLC* all payment from my insurance provider(s) for services rendered.

Initial ____

I understand that while courtesy confirmations **may** be offered, I alone am responsible for scheduling, keeping track of and maintaining my myofunctional appointments. I understand that appointments cancelled or changed with *less* than 2 business days' notice will be subject to a **$95** charge.

Initial ____

If the patient listed on this form is a minor, I confirm that I am financially responsible for services provided to the patient.

Print Patient Name: ____ **Initial** ____

My signature indicates I have read and agree to the *Financial Policy for Affinity Myo, LLC:*

Signature of Financial Guarantor: ______________________ **Date of Consent:** __________

Printed Patient Name (if not patient): ____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or have been offered a copy of *Affinity Myo, LLC*'s Notice of Privacy Practices.

Initial ____

Signature of Financial Guarantor: ______________________ **Date of Receipt:** __________

Printed Patient Name (if not patient): ____