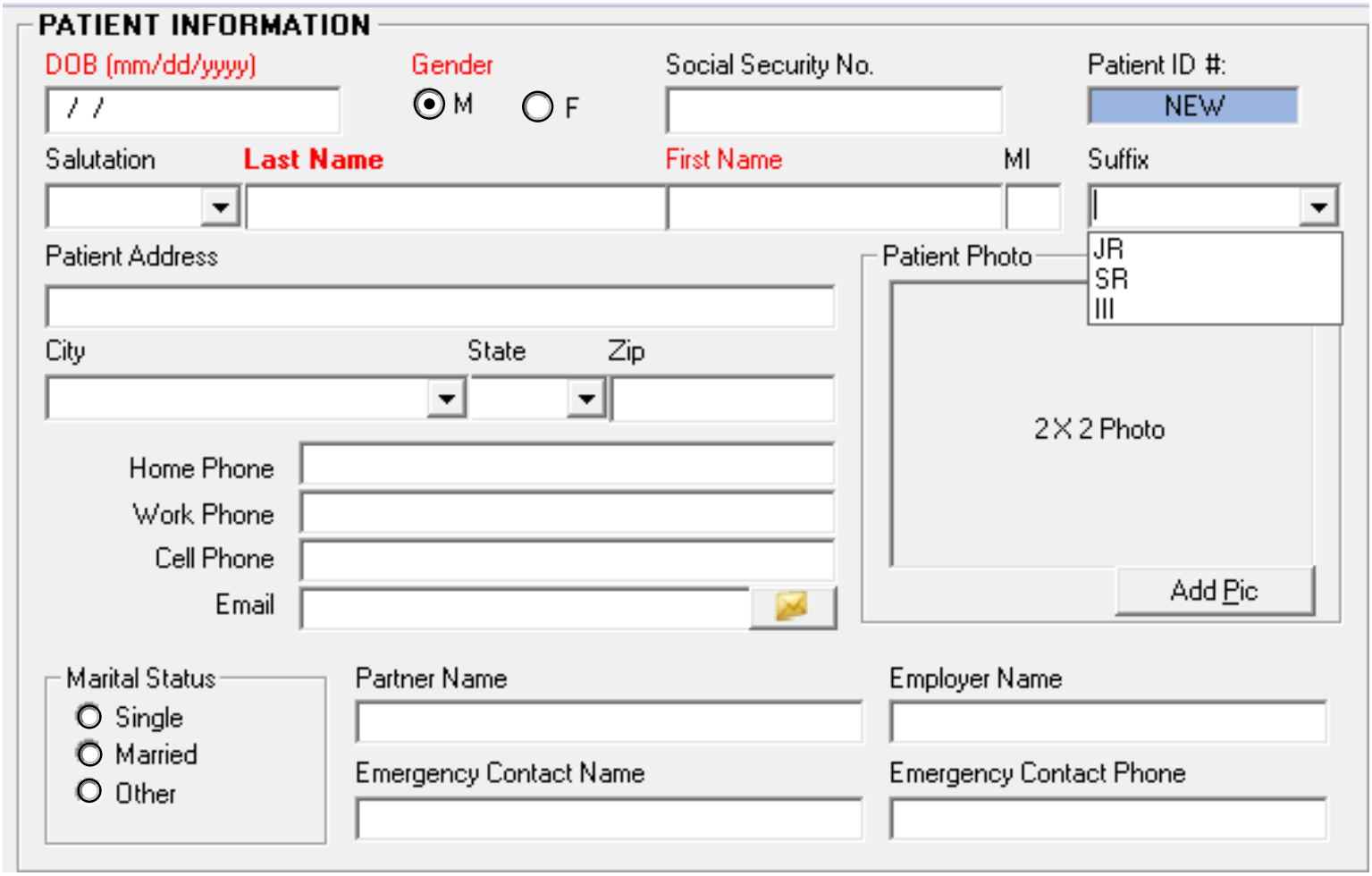
# EMERALD SPRING CLINICS




**I Will be paying today by: (Please Check One Box)**

☐ Having Emerald Spring Clinics file my insurance for me and I will pay my COPAY today.

☐ Paying for my office visit today with Cash, Check, or Credit Card.

I authorize the release of any medical information necessary to process claims and irrevocably assign to Emerald Spring Clinics all payments for services rendered. I understand that I am ultimately responsible for the balance of my account, whether or not any of the professional services rendered are covered by my insurance. I understand that my appointment will need to be rescheduled if I do not have my COPAY, my insurance information, or payment for my office visit today. I certify that this information is true and correct. I have received a copy of the Privacy Notice and have had an opportunity to object to the disclosures of my health care information.

_____/_____

**SIGNATURE** (if minor, Parent's Signature)/ **DATE**

**Thank you for choosing Emerald Spring Clinics!**