CANYON RIDGE
Pain Relief Specialists

Acknowledgement of Financial Responsibility

DATE_____

I, _____ , have been informed that Canyon Ridge Pain & Spine will bill my primary and secondary insurance as a courtesy. I acknowledge that any financial responsibility after the insurance has been billed will become due and payable in full within 90 days from the date the services were rendered. I understand that as courtesy statements will be mailed to my address on file. By signing below I agree that it will be my personal responsibility to ensure that my account balance has been paid in full within 90 days from the date services were rendered. If I fail to uphold this signed agreement I am fully aware that my account may be turned over to a collection agency. I understand that should my account be sent to a collection agency it will mean automatic dismissal from the practice.

_____ _____

PATIENT'S PRINTED NAME PATIENT'S SIGNATURE

PRINTED NAME & SIGNATURE OF WITNESS