DR. GARY BIRDSALL
MEDICAL CLINIC, LLC

102 W 112th Street, Cut Off, LA 70345 | Phone: 985-632-5222 | Fax: 985-632-4222

Patient Name: _____**DOB**: _____

ADVANCED NOTICE OF CHARGES

NOTE: You need to make a choice about receiving these health care items or services.

ITEM or SERVICE: _____

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

PLEASE CHOOSE ONE OPTION. CHECK ONE. SIGN & DATE YOUR CHOICE.

Option 1: Yes_____ I want to receive these items or services.

I agree to be personally and fully responsible for payment of these items or services, and that a reduction of charges is offered if paid in full at the time of service. If the balance is not paid in full at the time of service, I agree to pay for items or services on a payment plan as agreed upon by the office manager. I understand that other charges may follow this original estimate based on other tests that may be needed to provide medical care for me.

Option 2: No _____ I have decided not to receive these items or services.

I will not receive these services. I understand that you will not provide the items or perform the services that my doctor has recommended.

_____ _____

Date Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

This section is to be completed by Office Staff:	**Amount/Method of Payment:**	**Initials**	
Actual Charges	_____	_____	
25% prompt pay adjustment charges	_____	_____	
Deposit collected at check-in	_____	_____	ck. out _____
Balance due and collected	_____	_____	