FINANCIAL AGREEMENT

In consideration of the patient receiving services from Dr. Kevin Dodson, DPM, I agree:

- I am responsible for all expenses Incurred during my treatment.
- Payment of charges is due at the time of appointment.
- If Dr. Dodson's staff files my insurance for me, I agree to pay for non-covered insurance benefits, co-insurance, co-pays, and deductibles.

_____	_____
Patient Signature	Responsible Party's Signature (Parent/Guardian of Minor)
_____	_____
Printed Name	Printed Name
_____	_____
Date	Date

AUTHORIZATION TO RELEASE INFORMATION & TO PAY BENEFITS

I authorize Dr. Dodson and staff to release any or all of my medical information to my insurance company(s), as needed to process my insurance claim.

I authorize my insurance company to make payments directly to Dr. Dodson, DPM for covered medical and/or surgical services.

_____	_____
Patient Signature	Responsible Party's Signature (Parent/Guardian of a Minor)
_____	_____
Printed Name	Printed Name
_____	_____
Date	Date