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***Please remember that a Co-payment is for office visits only. This does not apply to addition tests and injections administered during your visit. Your deductible or a percentage rate will apply to these services.

Have you met your deductible for the year 2007? _____ yes _____ no

Do you have a Co-payment for office visits? _____ yes _____ no

Co-payments amount (for office visit only) $ _____

I realize that I am responsible for prompt of all Co-payments, deductibles, patient portions, and services not covered by insurance.

Patient acknowledgement:

_____ _____
Patient signature Date

_____
Print name