



John D. Marshall, M.D. **Daniel D. Smith, D.C.**
Summer Marshall, P.A.-C **Adam L. Schwartz, P.A.-C**

PATIENT AGREEMENT

Date: _____

I, _____, acknowledge that I have requested medical treatment, care, and/or services from Dr. Marshall, Dr. Smith, (individually, the “Doctor”) for injuries I sustained in an accident on _____. This Agreement is being entered into in consideration of the Doctor’s promise to provide continuing treatment and to forgo his right to immediate payment of his usual and customary charges. This Agreement is intended to be contractual in nature and not a mere recital.

As a condition of continuing treatment, I will provide all pertinent billing information to the business office, including the company name, policy number and claim number of any automobile or health insurance company that may provide coverage for the Doctor’s usual and customary charges. I covenant to duly present any insurance checks received by me for any charges, including the Doctor’s usual and customary charges, to the business office as long as there is a balance due on this account.

As a courtesy, the Doctor may bill my health insurance directly. I understand that Paradise Valley Family Care, PLLC does not warrant that charges submitted by the treating Doctor for treatments and/or supplies will be covered by my health insurance plan. **IT IS MY RESPONSIBILITY TO ENSURE THAT THE DOCTOR(S) AND SERVICES PROVIDED BY PARADISE VALLEY FAMILY CARE, PLLC WILL BE COVERED BY MY HEALTH INSURANCE PLAN.** I understand that I am ultimately responsible for all charges that I incur at Paradise Valley Family Care, PLLC, regardless of whether said charges are submitted to my insurance company.

EVEN THOUGH MY HEALTH INSURANCE MAY BE AN HMO OR PPO TO WHICH THE ABOVE DOCTOR BELONGS, I EXPRESSLY AGREE THAT SAID DOCTOR IS ENTITLED TO BILL AND COLLECT THE FULL AMOUNT OF HIS ‘USUAL AND CUSTOMARY CHARGES.’ I UNDERSTAND THAT THE DOCTOR’S ‘USUAL AND CUSTOMARY CHARGES’ ARE THE FULL AMOUNTS BILLED FOR SERVICES AND NOT THE CONTRACTED RATES PAID BY MY HMO OR PPO. PURSUANT TO A.R.S. § 20-1072(E), I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR THE USUAL AND CUSTOMARY CHARGES BILLED BY THE DOCTOR.

