MICHAEL A. ZIMMER M.D., F.A.C.P
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CONSENT FORM OF PATIENT RESPONSIBILITY

I hereby authorize Michael A. Zimmer M.D. and associates to bill my primary, secondary and tertiary insurance companies for payment of services rendered. I understand all co-payments, deductibles and out of pocket expenses are my responsibility and liability.

I understand that if my insurance companies do not pay for non-covered charges I am responsible for any and all balances due.

I also understand that it is my responsibility to inform the practice of any insurance coverage changes or lapses at the time of my visit or prior as to not delay payment for services.

***DATE*_____**

***PATIENT SIGNATURE*_____**