Kimberly P. Cockerham MD, FACS
Plastics-Orbit-Neuro-Ophthalmology

ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT OF SERVICE

I, ______________________, understand and agree to the following:

1. My health coverage involves an arrangement between my health plan and myself. If Dr. Kimberly P. Cockerham is NOT a contracting provider with my plan, I will be personally responsible for payment on the day of the appointment and/or prior to any service rendered.

2. Dr. Cockerham's office staff will do what they can to prepare necessary reports and forms to assist me in collecting appropriate reimbursement from my health care plan.

All of my questions have been answered and I feel comfortable with this professional and financial relationship.

Date	Print Name:	Signature of Patient/Guardian