1. PAYMENT: I assign and authorize payment, for any and all services rendered, directly to NEWLAND MEDICAL ASSOCIATES, P.C., from my insurance company or third party payor including, but not limited to, Medicare, Medicaid, BCBSM, Commercial health insurance companies, and workers disability compensation insurance.
   In consideration of the professional services rendered or to be provided to me, I agree to pay all charges not covered by my insurance company or any applicable health benefit including, but not limited to, deductibles, co-payments, non-covered services. I understand it is my personal responsibility to pay Newland Medical Associates, P.C., all charges for services rendered irrespective of any disputes or disagreements between myself and my insurance company.

I have read this consent form, or it has been read to me, and I am satisfied that I understand its consents. My questions have been answered to my satisfaction.

_____

Signature of Patient Date

_____

Witness Date