



## **Acknowledgement of Financial Responsibility**

In my capacity as patient, legal representative or representative payor for the below-named patient, I agree to pay all charges to Capitol Spine & Pain Centers for which I may be legally responsible, including, but not limited to, health insurance deductibles, co-payments, and non-covered services.

In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorney's fees and other collection costs incurred by Capitol Spine & Pain Centers in settlement of my account.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient name (please print) \_\_\_\_\_