



**Acknowledgement of Financial Policy**

I have been given a copy or have been told where to find a copy online of Dearborn Allergy & Asthma Financial Policy.

This is an agreement between Dearborn Allergy & Asthma Clinic and the patient/responsible party signed below. By executing this agreement, you are agreeing to pay for all services that are received.

***I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO ABIDE BY ITS GUIDELINES.***

Patient's Name: \_\_\_\_\_

Responsible Party (if not the patient): \_\_\_\_\_

Signature of Patient or Responsible Party: \_\_\_\_\_

Date of Signature: \_\_\_\_\_