Arthritis & Osteoporosis Center, P.C.
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I, _____, am aware that it is my responsibility to pay my copay/coinsurance at the time of my visit. However, I am not able to do so today. Please bill me for today's copay/coinsurance.

I understand that I **will** be billed a missed copay/coinsurance fee of $10 due to nonpayment at time of service.

DATE: _____

PRINT: _____
Patient Name

SIGNATURE: _____
Patient Name

Thank you.

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