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### **Acknowledgement of Financial and Patient Balance Policies**

**Patient Account Number** \_\_\_\_\_

**I, \_\_\_\_\_, have received the Financial Policy from Carolina Internal Medicine Associates.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\_\_\_\_ Patient was made aware and given a printout of delinquent balance in the amount of**

**\$ \_\_\_\_\_ as of the above date.**