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Financial Policy

Please initial each section:

_____ Payment and or copay/deductible is due at the time of service.

_____ I, the undersigned, hereby authorize the payment of medical benefits, including Medicare, Medicaid, private insurance and any other health or medical plan, directly to the provider for services provided to me. I agree and acknowledge that my signature on this document authorizes the provider to submit claims for services rendered and services to be rendered without obtaining my signature on each claim to be submitted for myself and or my dependents. I will be bound by this signature as though I had signed the claim.

_____ I under that insurance is considered a method of reimbursing the doctor for services rendered and is not considered a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and other insurance companies pay only a percentage of the charge. I understand that I am financially responsible for any deductible amount, co-insurance, out of network percentage, and or any other balance not covered by my insurance company.

_____ I authorize release to my insurance company, information concerning my health care, advice, treatment, or supplies provided to me. This information will be used for evaluating and administering claims of benefits.

The insurance information furnished here represents a full disclosure of the insurance / third party benefits to which I am entitled. I understand that failure to disclose or furnish full and complete insurance, Medicare, Medicaid information, pre-certification / second opinion requirements for all plans in which I subscribe may cause me to incur fill liability for professional charges, because of non-payment by any carrier.

A photocopy of this assignment shall have the same force and effect as the form bearing the patient's original signature.

Patient Name: _____

Patient Signature: _____ Date: _____