

Dear Patient:

You have selected "INSURANCE ASSIGNMENT" as the method of choice to take care of your financial obligation with this office.

It is important you realize that in this office we offer the option of "INSURANCE ASSIGNMENT" strictly as a courtesy to our patients, and, as such, our patients must understand and agree to the following:

- 1.) That you are considered a cash patient until you bring in completed insurance forms, and this office qualifies and accepts your coverage.
- 2.) That you are ultimately responsible for full payment for any and all services rendered.
- 3.) That you must pay all deductibles in full.
- 4.) That co-insurance must be paid at time of service.
- 5.) That if your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim and that after 90 days you will be responsible for payment in full for any outstanding balance.
- 6.) That after 90 days, you authorize us to use your credit card to collect full payment.

Credit Card \_\_\_\_\_ # \_\_\_\_\_ Exp. Date \_\_\_\_\_

- 7.) That in the event you discontinue your program of care prior to doctor's consent you are responsible for payment in full of any outstanding balance and the courtesy of insurance assignment will immediately discontinued.

This insurance assignment policy must be followed. We ask that you sign this form as acknowledgement that our policy was explained to you, you understand it and that you accept full financial responsibility.

Date: \_\_\_\_\_

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

Patient's Signature: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Witness: \_\_\_\_\_