ASSIGNMENT OF BENEFITS

I understand that by using my insurance in this office that it is my responsibility to do the following:

- Obtain a referral when necessary.
- Pay my copay at the time of my visit **(or if billed, pay a billing fee of $20.00 in addition to my copay).**
- Meet my insurance deductible if applicable.
- Pay for any expenses that are not covered by my insurance.

- I authorize release of information as necessary to process my insurance claim.

- I authorize my insurance company to pay this office for services provided to me.

- I understand that if my insurance coverage is invalid, that I am responsible for payment for services provided to me.

Patient or Authorized Representative:

Sign Here: _____

Print Here: _____

Today's Date: _____