

INSURANCE ASSIGNMENT OF BENEFITS

• **AUTHORIZATION TO RELEASE INFORMATION:**

I hereby authorize **F.O.R.M.E.** to release any information acquired in the course of my medical examination and treatment, including drug use, alcoholism, and HIV positive test results, to my insurance carrier(s) as necessary to process my insurance claim.

• **AUTHORIZATION TO PAY BENEFITS:**

I hereby authorize my insurance carrier(s) to make payment directly to **F.O.R.M.E.** for the surgical and/or medical benefits payable for the services rendered.

PATIENT SIGNATURE

INSURED'S SIGNATURE

Date _____

FINANCIAL AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT THE TIME SERVICE IS RENDERED.

If this account is assigned to and attorney/or outside agency for collection and/or suit, **F.O.R.M.E.** shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

PATIENT SIGNATURE

GUARANTOR'S SIGNATURE

Date _____

HOW DID YOU HEAR ABOUT US?

Referral by _____

Commercial TV/Radio

Newspaper

Counter Display Telephone Directory

Website

Billboard

Flyer/insert

Other _____

IN CASE OF AN EMERGENCY:

-- WHO SHOULD WE CONTACT --
(Please list someone living at a residence other those listed on the reverse side.)

Name: _____ Telephone Day (____) _____

Address: _____ Night (____) _____

City: _____ State: _____ Relationship _____