PATIENT FINANCIAL STATEMENT

AUTHORIZATION

I HEREBY AUTHORIZE THIS PHYSICIAN TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED

I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT. I FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIM, TO MY INSURANCE CARRIER, (OR, IN THE CASE OF MEDICARE PART B BENEFITS TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION), AND TO ANY CONSULTING PHYSICIAN. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR MY INSURANCE CARRIER AT ANY TIME IN WRITING.

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SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT OF ALL MEDICAL INSURANCE BENEFITS WHICH ARE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE POLICY TO BE PAID DIRECTLY TO DRS. DEIBOLDT AND BECK FOR SERVICES RENDERED. I FURTHER AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED FOR PROCESSING MY INSURANCE CLAIMS. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE COMPANY WITHIN 60 CALENDAR DAYS.

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SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

FINANCIAL AGREEMENT

I HEREBY ASSUME FINANCIAL RESPONSIBILTY FOR AND AGREE TO MAKE PAYMENT IN FULL TO DRS. DEIBOLDT & BECK FOR ALL CHARGES FOR SERVICES OR MEDICAL SUPPLIES FURNISHED TO THE ABOVE NAMED PATIENT NOT OTHERWISE AUTHORIZED OR PAID FOR BY MY INSURANCE CARRIER. PAYMENT IS TO BE MADE WITHIN 30 DAYS AS STATEMENTS ARE PRESENTED WITH SETTLEMENTS IN FULL, OR PAYMENT ARRANGEMENTS TO BE MADE WITH THE BUSINESS OFFICE. I UNDERSTAND THAT A 65.00 CHARGE MAY BE INCURRED FOR APPOINTMENTS MISSED OR CANCELLED LESS THAN 48 HOURS OF THE SCHEDULED APPOINTMENT TIME. I CERTIFY THAT THE FINANCIAL INFORMATION GIVEN IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE, AND FURTHER AUTHORIZE DRS. DEIBOLDT & BECK TO INVESTIGATE ANY AND ALL FINANCIAL INFORMATION GIVEN CONCERNING THIS OR RELATED CLAIMS.

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SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

REFERRALS (sign if required by insurance to use a referral)

IN AN EFFORT TO KEEP OUR PATIENTS INFORMED, WE WANT YOU TO KNOW AND UNDERSTAND SOME IMPORTANT INFORMATION REGARDING YOUR INSURANCE COVERAGE. YOUR INSURANCE CARRIER REQUIRES THAT YOU HAVE A CURRENT AND COMPLETE WRITTEN REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN (IN SOME CASES THE REFERRING PHYSICIAN MAY BE ABLE TO PROVIDE IT; CHECK YOUR CARRIER DIRECTLY). **IF THIS REFERRAL IS NOT PRESENTED PRIOR TO TREATMENT BEING RENDERED, YOUR INSURANCE MAY NOT COVER ALL OR A PORTION OF THE MEDICAL EXPENSES IN CURRED**. IN THIS INSTANCE, YOU ARE RESPONSIBLE FOR ALL UNCOVERED CHARGES. IT IS ALSO YOUR RESPONSIBILTY FOR ALL UNCOVERED CHARGES. IT IS ALSO YOUR RESPONSIBILTY TO ASSIST THE STAFF IN OBTAINING ADDITIONAL REFERRALS WHEN NECESSARY AND APPROPRIATE. IF YOU REQUIRE ADDITIONAL OR MORE SPECIFIC INFORMATION REGARDING YOUR INSURANCE COVERAGE, PLEASE CONTACT YOUR CARRIER DIRECTLY.

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SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

MEDICARE (sign if Medicare is your insurance carrier)

I UNDERSTAND THAT IN CERTAIN CIRCUMSTANCES MEDICARE MAY DECIDE THAT APPROPRIATE MEDICAL SERVICES ARE NOT MEDICALLY REASONABLE OR NECESSARY UNDER THE MEDICAL LAW. SINCE MEDICARE MAY DENY PAYMENT OF THESE SERVICE, I AGREE TO BE PERSONNALLY AND FULLY RESPONSIBLE FOR PAYMENT OF THE CHARGES.

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SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE