PATIENT FINANCIAL STATEMENT

AUTHORIZATION (signature REQUIRED)

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.

_____ _____

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY **DATE**

ASSIGNMENT OF BENEFITS (signature REQUIRED)

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 DR. DAVID DEIBOLDT 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.

_____ _____

SIGNATURE OF PATIENT, INSURED OR BENEFICIARY DATE

FINANCIAL AGREEMENT (signature REQUIRED)

I HEREBY ASSUME FINANCIAL RESPONSIBILITY FOR AND AGREE TO MAKE PAYMENT IN FULL TO DR. DEIBOLDT 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 PRIOR TO YOUR NEXT SCHEDULED APPOINTMENT WHICHEVER OCCURS FIRST AS A STATEMENTS ARE PRESENTED WITH SETTLEMENTS IN FULL. I UNDERSTAND THAT ANY DELINQUENT BALANCE WILL BE SUBJECT TO A MONTHLY REBILLING FEE OF $10. I UNDERSTAND THAT A 75.00 CHARGE MAY BE INCURRED FOR APPOINTMENTS MISSED OR CANCELLED LESS THAN 24 HOURS OF THE SCHEDULED APPOINTMENT TIME OR IF UNABLE TO PAY ANY BALANCE AT YOUR SCHEDULED APPOINTMENT TIME. I CERTIFY THAT THE FINANCIAL INFORMATION GIVEN IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, AND FURTHER AUTHORIZE DR. DEIBOLDT TO INVESTIGATE ANY AND ALL FINANCIAL INFORMATION GIVEN CONCERNING THIS OR RELATED CLAIMS.

_____ _____

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

REFERRALS (signature REQUIRED)

IN AN EFFORT TO KEEP OUR PATIENT 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 CASE THE REFERRING PHYSICIAN MAY BE ABLE TO PROVIDE IT; CHECK YOUR CARRIER DIRECTLY). **IF THIS REFERRAL IS NOT PRESENT PRIOR TO TREATMENT BEING RENDERED, YOUR INSURANCE MAY NOT COVER ALL OR A PORTION OF THE MEDICAL EXPENSES INCURRED.** IN THIS INSTANCE, YOU ARE RESPONSIBLE FOR ALL UNCOVERED CHARGES. IT IS ALSO YOUR RESPONSIBILITY FOR ALL UNCOVERED CHARGES. IT IS ALSO YOUR RESPONSIBILITY 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.

_____ _____

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 PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT OF THE CHARGES.

_____ _____

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE