UNDERSTANDING INSURANCE & PAYMENT AGREEMENT
REGARDING INSURANCE PAYMENTS

I understand that my insurance contract is an agreement between the insurance company and me. I acknowledge that your office is willing to prepare the necessary bills and reports and assist me in collecting from the insurance company that which is due to you for my medically necessary care and treatment.

I acknowledge and agree, that I am ultimately responsible to you for payment of any balances due, including unpaid deductibles co-pays and/or unpaid percentage amounts due to you according to my policy coverage. This goes as well as for any outstanding amounts due in the event you are unable to collect from my insurance carrier or attorney in the case where you are holding an attorney letter of protection or lien on my behalf. I understand that I will be billed for any fees, co- pays and deductibles at the time of visit, for services rendered that day, if that amount is known at the time of visit. Should the deductibles and/or co-pays not be known at the time of visit, I agree to pay for these amounts due as soon as I am notified either by my insurance company or by your office.

I will also be responsible to you for any fees that my insurance company refuses to pay, no matter what the reason after all efforts are made by your office to collect from them on my behalf.

Print Name: ____

Signature____ Date: ___________________________

<u>I elect to pay for co-pay and or deductibles by: select one of the following.</u>

Check #: _____ Cash ☐ Visa ☐ MasterCard ☐American Express ☐ Discover ☐Other

CREDIT CARD NUMBER: __________________________________ EXP. DATE: ________________

PATIENT SIGNATURE: _______________________________________ DATE: ____________________

REGARDING ATTORNEY LIENS

I understand that if I have an attorney involved in my case, and /or if there is no settlement or an incomplete settlement to cover my outstanding bill with your office, I will accept responsibility for the amounts due to you. I then agree to pay or to make payment arrangements as soon as I and/or you are notified of the outcome of the settlement.

I understand that as long as the attorney is working on my case, prior to final settlement, that you agree not to submit any bills to me or in anyway request payment from me for services. If, and when, I have need of an attorney, now or in the future, I agree to also sign an Attorney Letter of Protection for my attorney to sign and return to your office if and when necessary. I understand this letter is necessary to protect your bills in the event there is a settlement.

PATIENT SIGNATURE: _______________________________________ DATE: ____________________

NOTE: It is illegal, (In Florida) to bill a W/ C patient when authorized by carrier. Check your State's Workers' Comp Laws regarding this and other rules or laws pertaining to your Workers' Compensation case or provider reimbursement requirements.

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