

## **OUR OFFICE POLICY REGARDING INSURANCE ASSIGNMENT**

Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you in every way we can.

However, it must be fully understood that contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

Our policy regarding insurance assignment:

1. By our office accepting your insurance on assignment, as a courtesy our office will wait to be reimbursed but depending on individual circumstances this may be warrant.
2. If you discontinue care without the doctor's authorization, the balance of your account is due and payable in full within 30 days, even If your insurance has been filed, (if the insurance does pay, it will be refunded if you have zero balance.)
3. Your insurance should pay with 30-days. If your insurance has not paid within 60 days you must pay the balance due and be reimbursed by your insurance company when and if it pays.
4. We will bill your insurance on 30-day cycles as long as you are receiving health care in this office.
5. You are required to sign an "Assignment to Pay Physician" form and any other assignment documents required by your insurance company on your fist office visit.
6. Our office does NOT guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied, you are responsible for the full amount on your bill.
7. Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. However, if necessary, we will assist you to the best of your ability.
8. All special arrangements regarding finances must be signed by the administrator and patient and/or other representatives.

If you understand and agree with all of the above policies, please sign your name below and we will accept your insurance assignment.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Witness)

\_\_\_\_\_  
(Date)