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Signature on File

Assignment of Benefits and Financial Agreement

Client Name: **Date of Birth:**

INSURANCE (NON MEDICARE):

I understand that the provider is contracted for numerous health insurance plans. The provider will to the best of her ability make available the names of health care service plans with which they contract. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by the provider if I (the undersigned) belong to a plan with which there is no contractual relationship to provide health care.

MEDICARE:

I request that the payment of authorized Medicare benefits be made on my behalf for services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. The provider accepts the charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge. I understand that Medicare has a MNT benefit for persons with Diabetes. The benefit allows 3 hours of MNT the first calendar year and 2 hours of MNT every year thereafter without a copay.

NON-COVERED SERVICES:

I understand that the provider contracts with health care service plans related only to items and services which are "covered" by the plan. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by his health care service plan not to be covered. Examples of non-covered service include, but are not limited to, services not specified as being covered in the patient's contract with their insurance plan or not in the benefit summary the health care service plan furnishes to the patient; and treatment not authorized by that (their) plan. The undersigned agrees to cooperate with the provider to obtain all necessary health care service plan and insurance authorizations.

FINANCIAL AGREEMENT:

I agree that in return for the services provided to the patient by the provider, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the provider for payment. If an account is sent to an attorney or filed at small claims court for collection, I agree to pay collections expenses and reasonable attorney's fees as established by the court. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any health care benefits insuring the patient, or any other party liable to the patient, for medical services provide is hereby assigned to the provider. If co-payment and/or deductibles are designated by my insurance company or health plan, I agree to pay them to the provider.

Client Name: **Date of Birth:**

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Beneficiary Signature of Authorized Party SOF Date

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Provider Signature