Created 1/2009

FINANCIAL POLICY

Patient Name:
Medical Record No.:

FINANCIAL RESPONSIBILITY
All professional and diagnostic services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with the Central Business Office. As a courtesy, Vital Allergy and Asthma Center will file claims on an assigned basis, and resulting payments will be applied to the patient's account. By signing this form you acknowledge that you are responsible for any co-payment, coinsurance, or deductible amount determined by your insurance carrier or the full payment of services, if you do not have insurance coverage. If you do not wish to assign benefits and prefer to file your own claims, payment, of our standard fees for all serviced rendered will be due at the time of service, and upon request, you will receive the necessary statement from the practice to file your own claims.

STATEMENT OF ASSIGNMENT OF BENEFITS
By my signature below, I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, private insurance and any other health/medical plan, to issue payment(s) /check(s) directly to Vital Allergy and Asthma Center for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I acknowledge that I am responsible for any amount not covered by my insurance carrier.

This assignment will remain in effect for a period of one year from the date this assignment is granted, unless revoked in writing.

STATEMENT OF AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize Vital Allergy and Asthma Center to: 1.) release any information necessary to insurance carriers regarding my illness and treatments; 2.) to allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by either party in writing.

I have requested medical services from Vital Allergy and Asthma Center on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charged incurred in the course of treatment authorized.

I further understand that the fees I am responsible for are due and payable on the date that services are rendered, and I agree to pay all patient responsible portion(s) of the charges incurred immediately upon presentation of the statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date