

DR. BRIAN GOODWIN, ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

My signature at the bottom of this form authorizes payment for services rendered to myself or my dependent to be made directly to Dr. Brian Goodwin. This authorization is valid until I notify Dr. Brian Goodwin in writing that it is" revoked.

I understand that I am responsible for giving "Dr. Brian Goodwin" the correct insurance information at the time services are rendered. Dr. Brian Goodwin, agrees to bill your primary insurance carrier. If you have more than one insurance we will bill your secondary insurance one time as a courtesy. If payment is not received from your secondary within 60 days the balance becomes your responsibility. All insurance information must be provided to our office, at the time of service.

I understand that I am responsible for obtaining the proper referral and may be held responsible for charges not covered by my Insurance due to my failure to obtain the required referral.

I agree to pay for non-covered services under my insurance plan (services for which I have a policy exclusion).

I understand that Dr. Brian Goodwin is not responsible for knowing if the group/physician is a participating provider with my insurance carrier.

We at Dr. Brian Goodwin expect that all accounts should be paid by the receipt of the first two statements. If you~ account has not been settled either by payment in full or by contacting our billing department to set up a payment plan we will be charging a \$10 re-billing fee for statements sent. Your account will be turned over to collection if you do not fulfill the terms of your financial arrangements.

I understand that there is a fee \$25 fee for all returned checks.

I understand that if I do not call to cancel my appointment within 24 hours there will be a \$25 fee applied to my account.

I understand that I am responsible for all balances not paid by my insurance' carrier, including deductibles, co-pay, and co-insurance and out of network penalties. I further understand that if this balance is turned over to an outside collection agency that I shall be liable for all costs of collection and any attorney fees and or costs incurred by this office.

Patient or Patients Guardian or Legal Representative Signature

Date

Name of Patient or Guardian or Legal Representative

Relationship to Patient