

OFFICE POLICY INFORMATION

Your insurance is a method to receive reimbursement for fees you have paid to the physician for services rendered. Many companies have fixed allowance or percentages of payment based on your contract with them.

It is your responsibility to pay any deductible, co-insurance, or any other balance not paid by your insurance. We will assist you in receiving reimbursement, however, you are ultimately responsible for the charges.

Photocopies of your Insurance card(s) will be requested.

Assignment of Benefits:

I hereby authorize payment of benefits be made directly to David A. Herz, M.D.

I understand that I am financially responsible for all medical fees due which are not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverage is subject to coordination of benefits.

Authorization for release of medical information:

I authorize any holder of medical information about me to release said medical information about me upon the request from insurance companies with whom I have coverage or any public agency and its agents, including the Health Care Financing Administration to determine benefits for services provided.

I permit a copy of this authorization to be used in place of the original. I agree to pay and guarantee in full any and all charges for medical services provided to me (the patient) by David A. Herz, M.D.

Signature of patient: _____

If minor, signature is of responsible person.

Date: _____

