FINANCIAL AGREEMENT

Provider: Dr. R. Pines

CLIENT INFORMATION Name_____ DOB_____ SS#_____

Address_____ City_____ State_____ Zip_____

Phone #_____ Can we leave messages at this number: Yes_____ No_____

Gender: F_____ M_____ Other_____ Marital Status: M____ S____ D____ W____ Other_____

Employer:_____ Work Phone#_____

Address_____ City_____ State_____ Zip_____

SPOUSE/PARTNER INFORMATION: Name: _____ DOB_____ SS#_____

Employer:_____ Work Phone#_____

FINANCIAL RESPONSIBLE (If other than Client)

Name_____ DOB_____ SS#_____

Address_____ City_____ State_____ Zip_____

Ph#_____ Employer: _____ Work#_____

EMERGENCY CONTACT: Name_____ DOB_____ SS#_____

Address_____ City_____ State_____ Zip_____ Ph#_____

INSURANCE INFORMATION

Primary Insurance_____ Policyholder Name_____

Policyholder ID#_____ Group #_____ Employer_____

Secondary Insurance_____ Policyholder Name_____

Policyholder ID#_____ Group #_____ Employer_____

OFFICE POLICY: Payment is due at the time of service. You are responsible for all fees regardless of insurance coverage. We charge $25.00 for all returned checks. As a courtesy, we will submit claims to the above-named insurance company. Benefits quoted by your insurance company are not a guarantee of payment. If your insurance company has not paid your claim within 60 days, the payment of the claim will be your responsibility. We do not bill for the following: student insurance, retroactive Medicaid, victims and workers' compensation, or third parties listed in divorce decrees. All minors must be accompanied by a parent or legal guardian. If your insurance company requires an authorization or referral for your visit, you are responsible to obtain and maintain the authorization or referral. Our providers do not do disability paperwork or FMLA until you have been an established patient for at least 6 months.

ASSIGNMENT OF BENEFITS: I request that payment of authorized insurance benefits be made on my behalf to Richard J Pines, DO for any services furnished to me by Dr. Pines. I authorize the holder of medical information about me or any information needed to determine these benefits to be released to the insurance company(s) listed above.

Policyholder Signature or Responsible Party_____ Date_____

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