Please Read Carefully and Complete

I have read the Policy and Procedures and understand and accept the policies described above I would rather:

∆ Pay each visit in full (and file my own insurance)

∆ Pay my BCBS/Medcost/Medicare copay and other fees for each session and have my insurance filed for me

∆ Make an alternative plan that must be specific with payment plan options approved by Dr Ricardo Bierrenbach MD.

Patient Name Printed:____Date: _________

Patient or Responsible Party Signature:___________________________________Date: _________

Clinician Signature:____Date: _________

Witness:____Date: _________

Insurance Authorization

IN ORDER TO FILE YOUR INSURANCE FOR YOU, WE REQUIRE THAT YOU CHECK EACH BOX AND SIGN THE FOLLOWING SIGNATURE ON FILE FORM

∆ I authorize use of this form on all my insurance submissions.

∆ I authorize release of information to all my insurance carriers.

∆ I authorize that I am responsible for my bill.

∆ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carrier.

∆ I authorize payment directly to my doctor or health care provider, and herby assign my right to reimbursement for services rendered to Ricardo Bierrenbach MD.

∆ I permit a copy of this authorization to be used in place of the original.

Patient or Responsible Party Signature:___________________________________Date: _________