AUTHORIZATION TO BILL INSURANCE

Insurance Billing (Medical, Auto Insurance or Worker's Compensation)

I understand that I must pay all co-payments and/or co-insurances not covered by my insurance company at the time of check in for today's visit, and every visit hereafter. **Acupuncture of Jenkintown** will submit my claim for me to my insurance company. Although **Acupuncture of Jenkintown** verifies my insurance; I understand that this verification is not a guarantee of payment. I understand that any and all charges incurred at this office including co-payment, coinsurance, percentage due and/or deductibles or any other fees or services not covered by my insurance company are my responsibility. I understand that if these patient portions due are not paid at the time of service I will be subject to a $10.00 billing fee per month – no exceptions until the outstanding amounts are paid. I further understand that any unpaid balance over 90 days, can and will be sent to collections for recovery unless prior arrangements have been made.

I authorize my insurance benefits to be paid directly to **Acupuncture of Jenkintown**. I also authorize the provider to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time. No other records shall be released without my signed consent.

_____ Signature of Responsible Party Date _____

_____ Signature of Person Authorized to Consent Date _____