HAROLD F. ROTH, D.O.
GENERAL PRACTICE

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INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

This is an authorization statement to permit payment of benefits to Harold F. Roth, D.O. This authorization remains in effect until revoked in writing by the patient or legal guardian.

All professional services rendered by Harold F. Roth, D.O. are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our business manager.

Consent to Release Medical Records to My Insurance Company:

I, the undersigned patient or person acting on behalf of the patient, hereby consent to the release by Harold F. Roth, D.O. of information from my medical records to any person, organization, employer (if work-related injury) or review agency which is responsible or which Harold F. Roth, D.O. reasonably thinks may be responsible for the payment of my bills for services.

Financial Agreement:

I understand that Harold F. Roth, D.O. submits claims to insurance carriers as a courtesy to patients and that I am responsible for the balance owed. I agree to pay for all services rendered to me without regard to any benefit limitations imposed by any third party payor, unless other arrangements are made in advance, to pay any legal fees which may be incurred, and interest at the legal rate in attempts to collect my balance. I understand that Harold F. Roth, D.O. accepts no liability for failure to meet any pre/post certifications required by my insurance carrier and agree that such certifications has been or will be properly executed by me.

Assignment of Benefit:

I hereby assign to Harold F. Roth, D.O. those insurance benefit payments due to Harold F. Roth, D.O. and I authorize my insurance company to make payment directly to Harold F. Roth, D.O. I understand that I am financially responsible for any deductible and co-insurance and services not covered by my insurance plan.

I understand that, whether I sign as a representative, patient, legal guardian or as guarantor, that I am directly responsible and will pay for services rendered and not paid by insurance. An assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed a waiver of the right of Harold F. Roth, D.O. to require payment directly from the undersigned or the patient. Harold F. Roth, D.O. expressly reserves the right to require such payment.

I have read this form (or have had it read to me) and understand it. I agree that by signing this form, I am bound by what it says, whether I am the patient or someone acting on the patient's behalf.

Date:_____ _____
Signature of Patient/Representative

Date:_____ _____
Signature of Guarantor/Legal Guardian

If patient is unable to consent, complete the following:

Patient is a minor, _____ years of age, **or** is unable to consent because: _____

My relationship to the patient is: _____