

**A Note About Your Insurance**

With the diverse selection of insurance plans, levels of coverage, and frequent changes, it is not always possible for our office to keep abreast of all plan requirements. While we will do our best to assist and inform you of the requirements, YOU are ultimately responsible for understanding YOUR insurance policy and levels of coverage. If you have any questions or concerns regarding plan coverage and/or administrative requirements, we strongly recommend that you contact YOUR insurance company or YOUR employer to discuss these questions.

Furthermore, some plans require written authorization from your primary care physician (PCP) to see a specialist. Many of these forms cannot be issued retroactively. Therefore, YOU understand that it is YOUR responsibility to obtain a valid authorization from your PCP for each visit, and without this authorization you may NOT be seen. If you insist on being seen without YOUR insurance's proper authorization, YOU agree to waive YOUR health plan benefits. Additionally, YOU agree to be PERSONALLY and FULLY responsible for payment to *Aram & Lawhorn, PC* for any services rendered.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Patient Authorization to File Insurance Claims**

I hereby authorize *Aram & Lawhorn, PC* to apply for benefits for covered services rendered. I request payment from my insurance company and/or Medicare/Medicaid (if applicable) be made directly to *Aram & Lawhorn, PC*.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information including medical information for this or any related claim to my insurance carrier. I permit a copy of this authorization to be used in place of the original.

Either I or my insurance carrier may revoke this authorization at any time in writing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Financial Policy, Authorization For Treatment & Your Health Information**

I authorize treatment and agree to pay all fees and charges for such treatment. I understand that my co-payment and any outstanding balance on are due upon my check-in at the front desk. Furthermore, if I am unable to pay my balance in full, I will be required to reschedule my appointment. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. In the event legal action should be necessary to collect an unpaid balance due for medical services rendered by the providers of *Aram & Lawhorn, PC* I agree to pay reasonable collection and/or attorney's fees.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pending of claims thereon. All proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for their collection. (A copy of this assignment is as valid as the original).

Our office requires 24 hours advance notice to cancel or reschedule your appointment. Failure to comply with this will result in a failure fee of \$50.00.

I acknowledge *Aram & Lawhorn, PC* will use my information for the purposes of treatment, payment, and health care operations.

I acknowledge that I have been given *Aram & Lawhorn, PC's NOTICE OF PRIVACY PRACTICES*. I understand that if I have any questions or complaints I may contact the Facility Privacy Official.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date