Please Read Each Section Carefully, Initial All boxes and indicate Your Agreement By Signing at the Bottom

Financial Responsibility and Assignment of Benefits:

/_____/ All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. All unpaid balances will be considered delinquent 60 days from the date of service. Any delinquent accounts can be referred to a collection agency and will incur the cost of collection including reasonable attorney fees.

/_____/ I the undersigned, have insurance coverage with ____________________________________

Name of Insurance Company

And assign directly to SCC, all medical benefits to include all major medical benefits to which I am entitled. If any, otherwise payable to me for services rendered to myself and/or my dependents. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize SCC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

I understand that medical treatment of an immediate nature is necessary and that such care, treatment and procedures will be provided during office hours only. I grant authorization and consent to treatment and certify that no guarantee or assurance has been made to the results which may be obtained. I acknowledge that neither SCC nor any of its owners, officers, directors or employees shall have any liability, whether direct or indirect, if I do not follow the prescribed course of treatment, including prescribed return visits.

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to SCC for any services furnished me by their physicians and staff. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency shown.

Important Notice from the Government:

It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments, even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "Take What Insurance Pays" Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, and State Fraud laws:

Patient/Responsible Party Signature:____

Printed Name:____Date:__________________