

John Bull Center for Cosmetic Surgery & Laser Medispa

Patient Name:

ASSIGNMENT OF BENEFITS

The undersigned hereby authorizes the John Bull Center for Cosmetic Surgery & Laser Medispa or its designated agent, to request on my/our behalf and to collect directly all public and private insurance coverage benefits due for services provided by John Bull Center for Cosmetic Surgery & Laser Medispa. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to John Bull Center for Cosmetic Surgery & Laser Medispa all checks for such payment.

RELEASE OF INFORMATION

The undersigned authorizes the release of all medical records related to my care to authorized representatives of John Bull Center for Cosmetic Surgery & Laser Medispa, the patient's third party payer, physician, or other health care providers/vendors. I authorize the use of patient record information for the purpose of review of quality and case management activities. Furthermore, I authorize the patient's third party payer to release to John Bull Center for Cosmetic Surgery & Laser Medispa, or its designated agents, all information pertaining to the patient's insurance benefits and status of claims submitted.

AGREEMENT OF PAYMENT

In consideration of John Bull Center for Cosmetic Surgery & Laser Medispa providing me with services, the undersigned patient, spouse, guarantor and/or guardian agrees that each of them is responsible for payment to John Bull Center for Cosmetic Surgery & Laser Medispa for all services provided. The undersigned also agrees to provide John Bull Center for Cosmetic Surgery & Laser Medispa prompt notification of all changes in insurance benefits and/or coverage, home address and telephone number, and any other relevant information. I understand that I am responsible for payment of services rendered through insurance, private pay, and all other types of coverage. I understand that John Bull Center for Cosmetic Surgery & Laser Medispa will submit claims as a service to me, but that this service does not relieve me of my financial obligation. I agree to pay all invoices upon receipt and that I may be refused further service from John Bull Center for Cosmetic Surgery & Laser Medispa if I refuse to pay. Payment for services rendered is due within fifteen (15) days of the billing date. If said bill is not paid in full within thirty (30) days of the billing date, a penalty of one and one half (1 ½) percent (minimum \$1.50) per month will be assessed on the unpaid balance. In the event that the services of a collection agency and/or attorney are utilized to collect a bill, the responsible party will be liable for all fees charged by the collection agency as well as any legal fees incurred by John Bull Center for Cosmetic Surgery & Laser Medispa in connection with collection of the outstanding bill.

The undersigned consent to the review and release of his/her records by Federal and/or State Accrediting Body or Agency as required.

The undersigned certifies that he/she has read and understands the agreement. The undersigned also certifies that he/she is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accept the items.

NOTE: A duplicate copy of the copy of this agreement and consent shall be considered the same as the original.

Patient's Signature

Date

Spouse/Guarantor/Guardian/POA Signature

Date

