PAYMENT AUTHORIZATION
The Center for Balance

Assignment of Insurance Benefits

_____
Initials

I authorize that the payment of my insurance benefits be made directly to The Center for Balance for any services that are reimbursable by Medicare, Medicaid or any third party payors.

Guarantee of Payment

I understand that all payments designated as "the patients responsibility" are due and payable at the time of service or billing. I guarantee that I will pay:

_____
Initials
My designated portion including co-pays/co-insurance and my deductible

_____
Initials
All amounts due for services that my insurance company has stated are not covered benefits

_____
Initials
All amounts due for services billed but paid directly to me

_____
Initials
All amounts due for services billed to a Workers' Compensation payor which was subsequently declared by my employer to be a non-eligible claim

_____
Initials
All amounts due for claims submitted to my insurance company and not paid by 60 days

Medicare and Workers Compensation Information

_____
Initials
I certify that the information I have provided to The Center for Balance for payment under the Social Security Act (Medicare) or under the Workers Compensation Program is correct, including but not limited to any related accidents/illness or other insurers/payors available.

I, _____, understand the statements I have authorized above and declare their truthfulness
Printed Name

_____ _____
Patient or Authorized Representative for Patient Signature/Date Initials