

INSURANCE INFORMATION

Patient
Name: _____ SSN: _____ DOB: _____

Insured
Name: _____ SSN: _____ DOB: _____

Insured
Employer: _____ Bus. Tel: _____

Insur. Co: _____ Insur. Tel: _____

Addr: _____

Grp #: _____ ID #: _____

Financial Consent:

I understand that the payment of my bill is my legal obligation. Filing of insurance and confirmation of insurance payment to be made by my insurance company are my responsibility. Any assistance in this matter granted by Dr. Noguera, Dr. Russo and the office staff is given strictly as a courtesy and implies no responsibility on their part for filing, follow-through or confirmation. Also, we cannot negotiate a settlement on a disputed claim.

I authorize the release of any information related to my treatment to my insurance company, claims administrator and/or consulting health professional for the purpose of evaluating and administering claims for benefits.

If this account is placed in the hands of a collection agency or an attorney for collection, I agree to pay attorney fees of thirty three and one-third percent (33.3%) of the unpaid principal and interest owing, plus all court costs and interest in the amount of one and one-half percent (1.5%) per month, beginning thirty (30) days after the monies have become due or expenses have occurred. Annual percentage rate is 18%.

I authorize my insurance company to assign benefits that are payable to me to the office of Drs. Noguera and Russo, P.C. Any monies collected in excess of the billed amount will be returned to me.

Patient
Signature: _____ Date: _____