



**SOMA MEDICAL CENTER, P.A.
FINANCIAL ASSIGNMENT AND AGREEMENT**

Patient Name _____ **Parent/Guardian** _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is **NOT** a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance / HMO/ PPO plan.**

IN ORDER TO CONTROL YOUR COSTS, PAYMENTS FOR SERVICES RENDERED ARE EXPECTED TO BE PAID AT THE TIME OF SERVICE.

1. I authorize any holder of medical information about me to release the Health Care Financing Administration, its agent, or any insurance carrier or plan I may have, any information needed to determine these benefits payable for related services.
2. **If my Insurance/Medicare/Medicaid/HMO/PPO does not cover my care at Soma Medical Center, P.A. I agree to personally pay for all services rendered. I acknowledge that it is my responsibility to know my plan's coverage and inform Soma Medical Center, P.A. of any changes in coverage.**
3. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original.
4. **IF NO INSURANCE:** I understand and agree that I am responsible for all charges incurred regarding my medical treatment and that I will make payment at the time of service.
5. Any returned check will be charged the bank processing fee plus \$25.00.
6. If unable to keep appointment, kindly give 24 hours notice otherwise \$20.00 will be charged.

Patient / Parent / Guardian Signature: _____

Patient / Parent / Guardian Name: _____

Date: _____

Witness Signature: _____

Witness Name: _____

Date: _____