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: ______________________________