INSURANCE REGISTRATION AND POLICIES

Patient's Name ____ Date Of Birth __________

Insured ________________________ Rel. to Patient ____________________ Date Of Birth __________

Insured Social Security Number (or self) ____

Address (if different from patient) ____

City ________________________ State ____________________ Zip ________________________

Insured Employed By ____

Employer's Address ____

Primary Insurance According to insurance carriers, "eligibility for coverage **is not a guarantee** of any benefits. Your actual plan coverage and benefits, if any, are determined once your claim has been received and reviewed." Hence, we **do not** and **cannot** verify insurance, only that you may be eligible. Insurance is a contract between you and your insurance company, and we are not party of that agreement. We file claims (i.e. assignment) as a courtesy to our patients. The extent of your coverage depends on your individual plan. You should be aware that there may be portions of your care that you may have to self-pay as they may not be covered under your plan.

Please be aware that few insurance companies attempt to cover all medical costs. Many insurance companies pay on a fee schedule that is derived from providers outside of this region and may not be applicable for this area. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Our fees are based on national averages and are adjusted to the Crest Hill / Joliet, Illinois area.

By law, your insurance carrier must remit payment or deny your insurance claim within 30 days. If insurance problem should occur, we will be happy to assist you. However, after **sixty days,** if your insurance has not paid, you are responsible for the entire balance. In the event your insurance coverage changes to a plan in which we are not a participating provider, you will be responsible for payment of all fees at the time services are rendered. We also offer an extended payment plan under certain financial circumstances and may require the completion of a Financial Disclosure Form.

SECONDARY INSURANCE We do not accept assignment on secondary insurance plans. As a courtesy, we will gladly assist you with filing your secondary insurance claims.

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ________________________

Name of Insurance

and assign directly to Dr. Noey all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the of this signature on all insurance submissions.

________________________ ________________________ ____________

Patient/Responsible Party/Guardian Signature **Relationship** **Date**