OFFICE POLICY AND EXPLANATION OF COVERAGE

The following insurance and payment program allows you, our patient, to receive the care you need without undue financial strain.

- It must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance. Our office will NOT enter into a dispute with your insurance company over your claim. Our office does NOT guarantee that your insurance will pay.
- Your insurance should pay within 30 days after billing. If your insurance company has not paid within 90 days, you must pay the balance due and be reimbursed by your insurance company, when and if it pays.

I hereby instruct and direct my insurance company to pay by check, made out and mailed directly to Dr. Michael Krauseneck, the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered to me. In the event my insurance is a reimbursing contract and I receive payment from my insurance carrier, I agree to bring in the checks and endorse them over to the clinic within one week of receipt. A photocopy of this assignment shall be considered as effective and valid as the original.

I agree to be financially responsible for all charges incurred at this office including, but not limited to, insurance deductibles, co-payments and any services rejected by my insurance company. Co-pays, co-insurance, and other out of pocket expenses for services are expected to be paid the day of service.

I have read the above provisions and hereby agree to abide by them as specified above.

_____ _____

Patient/Parent/Guardian Signature Date

FEMALE PATIENTS ONLY

VERIFICATION OF NON-PREGNANCY

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Phone Number: _____ Date of Birth: _____

By my signature on this form, I do hereby state that, to the best of my knowledge I am not pregnant, neither suspected nor confirmed at this particular time.

Patient/Parent/Guardian Signature: _____

Doctor's Signature: _____

Witness Signature:_____