

# READ AND SIGN

ASSIGNMENT OF INSURANCE **AND** FINANCIAL AGREEMENT:

I HEREBY AUTHORIZE MY SIGNATURE ON ALL INSURANCE AND MEDICARE CLAIM FORMS FOR THE OFFICE OF ALL IN ONE FOR PAYMENT DIRECTLY TO HIM/HER FOR SERVICE RENDERED TO ME/PATIENT. I AUTHORIZE THIS OFFICE TO MAKE AND SEND COPIES OF MEDICAL RECORDS THAT MAY BE NEEDED TO FILE MY INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES INCURRED REGARDLESS OF WHETHER MY INSURANCE PAYS OR NOT. I UNDERSTAND THAT IF ANY UNPAID BALANCE IS ASSIGNED TO THIRD PARTY COLLECTION AGENCY FOR COLLECTION OR PLACE WITH AN ATTORNEY TO OBTAIN JUDGEMENT OF OTHERWISE SATISFY PAYMENT ON MY ACCOUNT, A COLLECTION FEE OF 33 1/3 PERCENT WILL BE ADDED TO MY ACCOUNT I AGREE TO PAY THAT FEE I ALSO AGREE TO PAY REASONABLE ATTORNEY FEES AND COURT COSTS. I UNDERSTAND AND AGREE TO THE ABOVE TERMS.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_