Patient's insurance and billing authorization

I hereby authorize the processing of the medical insurance either by electronic or manual method by the listed provider below. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer below to pay the listed provider assignee. I further authorize the assignee to release all medical and/or insurance claim information necessary to secure the payments(s) from the insurance company or the patient. (OR in the case of a minor child the parent)

I recognize my financial obligation of any co-insurance, co-pay or deductible and non-covered services that may be required. I understand that a $5.00 per month rebilling fee may be charged to any account that is not paid within 60 days. A $20.00 return check fee will be charged on all checks returned unpaid.

Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account.

This agreement will remain in effect until revoked by me in writing. A copy is considered as valid as an original.

Patient Name(please print)

_____

Patient signature(or in the case of a minor child the parent)

_____

Patient's insurance company

_____

Insurance ID number

_____

Date_____

Provider

Kenneth N Coates, DPM
1512 N Union Blvd
Colorado Springs, Co 80909