Office Use Only

Patient Note(s): _____

Assignment, Release and Financial Agreement

Assignment, Release and Financial Agreement: I authorize the staff to perform any necessary services needed during diagnosis and treatment of the person named below, and further agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for non-covered services, as well as for any/all balances due. I also authorize the physician to release any information to referring/consulting physicians or other health care providers as the physician deems appropriate to facilitate my/our care, and as required to process insurance claims. I understand that above information guarantees this form has been correctly completed to the best of my knowledge. I further agree that I will not withhold or delay payment if my insurance company denies payment of any of my charges. I have also been informed of the $35.00 fee on checks returned, per RCW 62A.3 515 & 520. In the event it should be necessary to place for collection an unpaid balance due for services rendered to me of my family, I/we agree to pay interest, collection fees, and should legal action be filed, reasonable attorney fees, filing fees and any other costs.

For Patients with Medical Insurance Benefits: CORE Injury Management participates with many insurance companies and Medicare. The business office will submit a claim for any services rendered to a patient who is a valid member of one of these plans. I understand it is my responsibility to provide all necessary information and notify the office immediately with any changes. If I am a member of an insurance plan with which CORE Injury Management does not participate, I agree that payment is expected at the time of service. It is my responsibility to contact my insurance company with any questions about my insurance coverage.

CORE Injury Management **CANNOT** waive co-payment, deductibles, co-insurance or non-covered insurance amounts defined as patient responsibility under the terms of our contract with the various health plans. I understand that co-payments are due at the time of service. I understand that any remaining balance on my account after the insurance company has processed my claim is due upon receipt of a statement from CORE Injury Management.

For Patients with no Medical Insurance Benefits: I understand that if I do not have group or individual medical insurance, I am expected to pay for all services provided at the time of service. Please inform CORE Injury Management in the event of difficulty in paying your account.

Missed Appointments: I understand that failure to provide a 24-hour notice of cancellation of an appointment or not showing up for an appointment will result in a charge of $75.00 on my account. This charge cannot be billed to the insurance company and will be my responsibility. Failure to pay a no-show fee will be treated according to CORE Injury Management policy on unpaid balances, with the exception of collection accounts. **Patient Initials**

Methods of Payment: Cash, personal check, Visa or Mastercard are accepted methods of payment by CORE Injury Management for professional services.

Returned Checks: I understand that any checks returned by my bank will result in a $35.00 return check fee charge to my account. Once a returned check is received by the CORE Injury Management office, checks will no longer be accepted. I understand that in this case, I am expected to pay my obligations by cash or credit card.

Past Due Accounts: I understand that patient balances that remain delinquent after 90 days, with no response to CORE Injury Management's requests for payment, will be referred to a collection agency. Once an account is turned over to collections, I understand that I will then have to settle the debt with the agency. If a balance remains unpaid, I understand I and/or my immediate family members may be discharged from CORE Injury Management. Should this occur, I will be notified by regular and certified mail that I have 30 days to find alternative medical care. During that 30-day period, CORE Injury Management will only be able to treat me on an emergency basis.

If you have questions on this policy, please contact our office at 425.270.3152.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Printed (Patient)**:**	**Signed** (Patient)**:**	**Date:**

Yearly Update

- I certify that I have reviewed the information on this form in its entirety, and there are ***no changes.***

Printed (Patient)**:** _____ **Signed** (Patient)**:** _____ **Date:** _____

- I certify that I have reviewed the information on this form in its entirety, and there are ***no changes.***

Printed (Patient)**:** _____ **Signed** (Patient)**:** _____ **Date:** _____

- I certify that I have reviewed the information on this form in its entirety, and there are ***no changes.***

Printed (Patient)**:** _____ **Signed** (Patient)**:** _____ **Date:** _____