



## CONSENT for Financial Agreement

**Assignment, Release and Financial Agreement:** I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider or service and I understand that I am financially responsible for non-covered services. I also authorize the physician to release any information required. I agree that I will not withhold or delay payment if my insurance company denies payment of any charges or pays the payment directly to me. I am financially responsible for a billing fee and understand that balances over 60 days may incur a billing fee or \$5.00 per month, with a minimum charge of \$1.00 per month. I have also been informed of the \$25.00 fee (per RCW 62A.2515\$520) on checks returned for NSF. IN the event it should become necessary to place any unpaid balance due for services rendered to me or my family for collection, I/we agree to pay interest, collection fees and should legal action be filed, reasonable attorney fees, filing fees and other costs the court determines proper.

**Medicare Authorization:** I authorize the doctor to release to the Federal Government or its designated agent information on this or related medical claims. I permit a copy of this authorization to be used in a place of the original and request payment of my insurance benefits are made to me or the doctor if assignment is accepted.

**Phone Message:** I authorize Peninsula Dermatology & Laser Clinic to leave messages at my home or alternate number I have provided for all administrative issues.

**\*\*This is the exact copy of what you are signing your consent to in your Electronic Medical Record.\*\***