Charles Bailey, M.D.

FINANCIAL RESPONSIBILITY FORM

Assignment of Benefits

PLEASE READ CAREFULLY BEFORE SIGNING.

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ALL INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

- I assign all medical and / or surgical benefits, including major medical benefits to which I am entitled to Charles Bailey, MD. This assignment will remain in effect until revoked by me in writing, A photocopy of this assignment is to be considered as valid original.
- I understand that if I receive any payments due to Charles Bailey, MD, it is my responsibility / obligation to immediately remit the payment to Charles Bailey, MD. I further realize that if I fail to do so, I am responsible for the bill in its entirety.
- If my insurance benefits are cancelled, and I continue to receive services, I agree to pay all bills in full.
- I also agree to cooperate with my insurance company in submitting all forms they request. Should I fail to do so, and thus payment is denied, I agree to pay the bill in its entirety.
- I also permit that a copy of this assignment be used in place of the original. This assignment is in effect until I choose to revoke it in writing,
- INSURANCE COVERAGE does not necessarily mean FULL coverage, and I understand that I am personally responsible for all co-payments and deductibles.

I/We further agree that the account may be placed for collections when it becomes 30 days past due. I hereby acknowledge that I have read the above, or have had the above read to me and that I understand the terms of this agreement.

PATIENT'S SIGNATURE _____ DATE _____