Authorization Information

Name: _____ DOB: _____ Date: _____ Patient # _____
Office Use

Assignment of Benefits:
I hereby assign to Vernick & Gopal, LLC, any insurance or other third-party benefits available for health care services provided to me. I, also, understand that if benefits are assigned, or if by contractual arrangement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the above practice has the right to refuse or accept assignment of such benefits (except when prohibited by contract). I, also, understand that in the event that services rendered are not covered under my "insurance"; I will accept financial responsibility for all services provided to me and give my consent for the above practice or parties on their behalf to contact me at the telephone numbers I have provided in regards to any insurance or outstanding billing issues. If benefits are not assigned to this practice, I agree to forward to the practice all payments that I receive for services rendered to me immediately upon receipt and/or to make payment, in full, for the services rendered at this time.

Signature of Patient or Legal Guardian: _____

Referral Acknowledgement:
I understand that if at any time my insurance plan requires a referral or prior approval and I receive care without it, my insurance plan may not cover my services and I agree to pay all charges. I understand that I am responsible to pay for the services rendered including attorney fees and cost or collection in the event of default.

Signature of Patient or Legal Guardian:
_____

Privacy Notice:
I understand that I may request a copy of the Vernick & Gopal, LLC Privacy Notice from the office staff at any time.

Signature of Patient or Legal Guardian:
_____