Lifetime Insurance Assignment and Authorization Form

Medical Center Clinic is pleased to file insurance for our patients. In order to correctly process your insurance claims, the patient or responsible party is responsible for providing, at the time of service, the most current address, phone number and insurance information.

I authorize payment directly to Medical Center Clinic, of benefits otherwise payable to me by my insurance company(ies). I do hereby assign, set over and transfer to the Medical Center Clinic my right to proceeds from any insurance company who is or may be liable at any time for all or part of my charges on this account to the extent necessary to pay such charges in full. If my insurance does not pay the Clinic directly, I agree to pay the amounts equal to all health insurance benefits which I receive for medical care at the Clinic immediately upon receipt of such payments.

I authorize Medical Center Clinic to release to my insurance carrier or it's representative any information needed from my medical records concerning the examination or treatment rendered to my that is necessary to process an insurance claim.

Patient Name	Signature*	Date

*If patient is under 18 and unmarried, parent/guardian must sign below.

Parent/Guardian	Signature*	Date

Statement of Financial Responsibility

I acknowledge I am responsible for all charges for Medical Center Clinic, services provided to me, whether incurred in the past or future, including any amount not paid and/or not covered by my insurance or other third party payors, excluding contractual insurance adjustments. I understand that Medical Center Clinic will not accept responsibility for collecting insurance or negotiating the settlement of a disputed insurance claim. I agree to pay the charges for care provided to the patient Medical Center Clinic within sixty (60) days of the date of the first monthly bill. Any account not paid in full within sixty (60) days of the date of the first monthly bill is considered delinquent. Should collection action become necessary, I agree to pay reasonable attorney's fee, expenses and court costs incurred by Medical Center Clinic.

I have read and understand the terms stated above. These terms and conditions constitute my complete agreement and may be modified only by written agreement signed by an authorized official of Medical Center Clinic. I acknowledge receipt of a copy of this agreement.

Account Responsible Party	Signature	Date

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