

INSURANCE INFORMATION

NAME: _____

NAME OF INSURED: _____

ADDRESS: _____

DATE OF BIRTH: _____

PHONE NUMBER: _____

DATE OF ACCIDENT OR FIRST SYMPTOMS: _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____

CLAIM NUMBER: _____

PHONE NUMBER: _____

BILLING ADDRESS: _____

REFERRING DOCTOR: _____

PHONE NUMBER: _____

FOR OFFICE USE

PRESCRIPTION: _____

DIAGNOSIS CODES: _____

**ASSIGNMENT OF FIRST PARTY INSURANCE BENEFITS
AND/OR SETTLEMENT PROCEEDS**

Date of Injury: _____

Patient's Name: _____

Patient's Insurance: _____

Party Causing Injury: _____

Other Party's Insurance: _____

TO: Water Lily
(Clinic Name)

1. In exchange for the Clinic treating me and waiting for payment of the bill until insurance benefits of monies from the settlement of my tort claim are available, I hereby irrevocably assign the right to receive those benefits or settlement monies to the Clinic. I hereby instruct any insurance company or attorney to pay any sums due me directly to the Clinic, up to the amount of my outstanding bill.
2. I agree that a photocopy of the document, including my photocopied signature will be as valid and binding on all parties involved as the original.

DATED this _____ day of _____, 20____

PATIENT SIGNATURE

PARENT OR LEGAL GUARDIAN FOR
CLINIC'S PATIENT

PAYMENT POLICY AND PATIENT AGREEMENT

Welcome to Water Lily. We are pleased you chose our clinic. We will do whatever we can to get you back on the road to health as soon as possible. Please take a moment to read and sign the following patient agreement. If you have any questions regarding our payment policy, please do not hesitate to ask the Doctor or staff.

OUR PAYMENT POLICY:

Unless other arrangements are made, our policy on payment of care is to require payment at the time of treatment.

IF YOU HAVE INSURANCE:

If you have insurance, the Clinic will cooperate in processing your insurance claim and will wait for payment by your insurance company. If your insurance only covers a percentage of your bill, you are required to pay you percentage or co-payment at the time of treatment. If your insurance company does not pay within (60) days from the date of treatment, you are required to pay the Clinic directly. If your insurance company does not pay you bills in a timely manner, the Clinic may require future treatment be paid for at the time of service.

ACCIDENT CASES:

If you are injured by someone else, and have no insurance to cover your bill, the Clinic will cooperate with you in processing your claim against the person who injured you. The Clinic may agree to wait for payment of your bill from the proceeds of any settlement or judgment. However, you are still responsible for payment, whether or not you collect from the insurance company or the person who caused you injury. If the Clinic agrees to wait for payment, you and your attorney must cooperate with the Clinic and sign an assignment of the insurance or settlement proceeds, so payment will be made directly to the Clinic when your case is concluded.

INJURIES AT WORK:

If you were injured on the job and your treatment is covered by workers' compensation, the Clinic will bill the workmen's compensation department and no payment by the patient is required.

LATE FEES:

Any treatment bills remaining unpaid after (60) days will bear interest at the rate of 12% until paid. If the Clinic has to hire an attorney or collection agency to collect past due bills, you must reimburse the Clinic for any attorney fees, court costs and collection charges spent in collecting the bill.

AUTHORIZATION TO RELEASE INFORMATION:

You give the Clinic permission to release information about your physical condition to any insurance company or attorney in order to process you bills for payment.

DATE: _____

PATIENT'S SIGNATURE

ADDRESS

HOME PHONE

WORK PHONE

If I sign this document as a parent or guardian of a minor child about to be treated by the Clinic, I understand I am responsible for payment of the care my minor child receives at the Clinic.

PARENT/GUARDIAN: _____