# PAYMENT AUTHORIZATION/FINANCIAL AGREEMENT

*This form is a release of information, benefit assignment, payment authorization, full disclosure statement, and agreement to pay for professional services.*

I _____, authorize Hedberg Allergy & Asthma Center, PA, to release any information acquired during the course of my examination or treatment to my insurance company and Northwest Arkansas Billing Company, LLC for the purposes of processing my insurance/medical claim. I agree to allow a photocopy of my signature to be used to process my insurance/medical claim for the period of Lifetime. I claim any insurance benefits due me for services rendered by Hedberg Allergy & Asthma Center, PA and authorize and assign payment directly to Hedberg Allergy & Asthma Center, PA, regardless of my insurance benefits.

I understand that I am financially responsible for any and all fees incurred, and I agree to pay such fees in full. I understand that failure to pay such fees will result in legal action in the **Small Claims Court, City of Rogers.** In addition to the unpaid debt, I understand that I will also incur court costs and other legal fees.

It is the policy of this practice that a divorced parent who seeks care for their minor child becomes the responsible party. Thus, Hedberg Allergy & Asthma, PA and shall not negotiate billing issues of separated or divorced parents regardless of your custody agreement. The parent that brings the child to the initial visit is responsible for payment at the time of service.

I have fully disclosed all information concerning the insurance/third-party benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by any carrier.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____

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