Patient's Name

Date of Birth

Practice Administrator
9450 E Ironwood Square Dr.
Scottsdale, AZ 85258
Phone: (480) 551-0581
Fax: (480) 551-0585

INSURANCE FINANCIAL AGREEMENT

I understand that by placing my signature on this page, I agree to the following:

- I am consenting to treatment and services ordered by my Physician to be performed by Dr. Corwin D. Martin.
- I understand that I am financially liable for all services performed that are not covered by my health insurance or if my coverage is not in affect at the time these services are rendered.
- I understand that I am responsible for confirming my coverage limitations and policies set forth by my insurance company.
- I understand that any referrals or authorizations needed for the visit are my responsibility to obtain prior to my visit. I realize that I may not be able to be seen if these referrals and/or authorizations are not in place and I will be financially responsible for payment.
- I authorize my insurance company to make payment directly to Dr. Corwin D. Martin.
- I understand all payments are due at the time services are provided, which includes co-pays. Payment arrangement must be made with the billing department PRIOR to my visit, if needed.
- I understand there is a $25.00 fee for all returned checks.
- I agree, if my account is turned over to a collection agency for non-payment, to pay the fees of the collection agency equal to the maximum of 25% of the outstanding balance at the time the account is placed with the collection agency. Interest of 10% per year will be accrued on the principal balance placed with the agency. Should legal action be necessary to collect the account, I agree to pay attorney's fees and court costs incurred for collection. I understand that any outstanding bad debts, for which I am not making consistent monthly payments, will be reported to the CREDIT BUREAU.
- I authorize Dr. Corwin D. Martin to disclose all or part of my medical and/or financial records to my insurance company or Third Party Payer, which may be needed to assist in payment of services rendered. This may include utilization review organizations, hospital or medical service companies, governmental agencies, or the patient's employer (if it is a self-funded insurance plan). I understand that this may be revoked by me at any time, except to the extent to which action has been taken in reliance upon it. The authorization will stay in effect as long as the need for information exists.

I have read and understand this agreement:

Patient's (or Legal Guardian's) Signature Date

Print Patient's (or Legal Guardian's) Name/Relationship Date

Patient's Initials __________

Estetica Cosmetic and Reconstructive Surgery of Scottsdale
9450 E Ironwood Square Dr., Scottsdale, AZ 85258
Phone: (480) 551-0581 | Fax: (480) 551-0585