# INSURANCE BILLING AGREEMENT

I understand that I am financially responsible for any charges incurred. It is my responsibility to contact my insurance carrier if there is a problem obtaining payment. I understand that if my insurance carrier does not submit payment within 30 days of the claim submission date I may be asked to pay for the charges. If my insurance carrier submits payment after I pay, I may receive a refund for certain monies paid.

I authorize the release of any medical information necessary to process any medical claims for services by Wholeness Center, P.C. Also, I authorize payment of medical benefits to physician or supplier for services described. I understand that certain office procedures are billed using an outpatient code which means I may have an out of pocket expense depending upon how my insurance covers out-patient services. This out of pocket expense may be in addition to my office co-pay depending upon my insurance guidelines.

I understand that I may receive reimbursement or payment directly from my insurance carrier for billing submitted by and due to Wholeness Center, P.C. I agree that I will promptly remit the payment to Wholeness Center, P.C. upon receipt of the check from my insurance carrier.

In the event full payment is not made for services rendered or in the event I fail to remit reimbursement payments received from my insurance carrier that are payable to Wholeness Center, P.C., I understand Wholeness Center, P.C. may be forced to take collection or legal action. I agree I will be liable for additional expenses, such as legal fees, interest on the unpaid portion of my account balance, and collection fees.

____________________________________ ________________

INSURED signature Date

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PRINTED patient's name