**1. INDIVIDUAL’S FINANCIAL RESPONSIBILITY**

• I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.

• Co-payments are due at time of service.

• If my plan requires a referral, I must obtain it prior to my visit.

• In the event that my health plan determines a service or device to be “not payable” or “non-covered service”, I will be responsible for the complete charge and agree to pay the costs of all services and devices provided.

• If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

**2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**

• I hereby authorize and direct payment of my medical benefits to Advanced Biomechanics on my behalf for any services furnished to me by Advanced Biomechanics.

**3. AUTHORIZATION TO RELEASE RECORDS**

• I hereby authorize Advanced Biomechanics to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and records of any treatment, devices or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical providers.

**4. MEDICARE REQUEST FOR PAYMENT**

• I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by Advanced Biomechanics. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

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