

#### INSURANCE

I hereby authorize Dr. Robert Sikora to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medial information for this or any related claim, to my insurance carrier, (or, in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration). A copy of the authorization may be used in place of the original.

This authorization may be revoked at by either me or my insurance carrier at any time in writing.

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Initials

#### ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly Dr. Robert Sikora for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. I understand and agree that I am financially responsible for charges not paid by my insurance company.

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#### PAYMENT POLICY

Payment for services is due at the time services are rendered. All returned checks are subject to a **\$25 return check fee**. If it becomes necessary to refer my account to an outside collection agency, I agree to pay 33.3% interest on the debt.

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#### APPOINTMENT POLICY

If you are unable to keep a scheduled appointment, we ask that you give us at least 24 hours notice. **“No Shows” are charged a \$50.00 fee**. Your insurance company will not reimburse these charges.

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