
**Authorization to Bill Health Insurance/Assignment of Benefits**

I, _____, do hereby give full permission and authorize Pearl Medical Clinic, to bill _____ (Name of Insurance Company) for services rendered by Pearl Medical Clinic. I also agree to have any checks or payment made by said insurance company to be payable and deliverable to:

***Pearl Medical Clinic, 2727 Bolton Boone Dr, Ste 101, Desoto, TX 75115***

**By signing this document, I also agree to the following statements below:**

I understand that I am responsible for understanding information about my health insurance policy and providing such information to Pearl Medical Clinic in the case of change of my health insurance status-inclusive benefits and any information I receive relating to care I have or will receive in this office.

I understand that Pearl Medical Clinic will be providing services and billing my health insurance for those services at various times during my care at this office. I understand ultimately, I am responsible for all payment relating to any and all charges relating to treatment and services that I have received at Pearl Medical Clinic during my care. I also understand that my insurance company and related policy plan may offer benefits for services provided at Pearl Medical Clinic, but that such benefits do not necessarily guarantee payment for those services.

I understand that the policy of Pearl Medical Clinic requires payment in full for all services rendered at the time of visit, unless other financial arrangements have been made. If my account is not pain within 90 days of the date of service and no other financial arrangements have been made, I will be responsible for all legal fees, collection agency fees, and any other expenses incurred in collecting my account (normal charge – 33% in addition to your outstanding balance in our office). I understand the above information and agree that my health history and related information was completed correctly to the best of my knowledge and understand that it is my responsibility to alert Pearl Medical Clinic of any change in my medical status or insurance coverage.

***The undersigned does agree to observe and abide by all the statement made above.***

_____ _____

**Patient's Signature** **Date**

_____ _____

**Representative of Pearl Medical Clinic** **Date**