Dr. Iwona L. Ciba
25722 Kingsland Blvd, Suite 201B • Katy • TX 77494
Tel. (281) 395-9966

Authorization/Responsibility Agreement

I hereby authorize any insurance company to pay the
Proceeds of any benefits due me directly to:

Iwona L. Ciba D.P.M, P.L.L.C.

A copy of this can be considered as an original for insurance purposes.

Signed _____ Date _____

I hereby agree to pay my account as services are provided.
If for any reason there is a balance owing on my account,
I agree to pay promptly upon receipt of the monthly statement.
If your insurance requires a referral, it is your responsibility to provide our office with it.
If insurance denies payment -DUE TO NO REFERRAL – patient agree to pay in full for any charges incurred.

Signed _____ Date _____

I acknowledge and understand that I am responsible for all of the charges,
for all of the services rendered to me or any member of my family.
Although I have requested the doctor to bill my insurance company on my behalf,
I clearly understand that it is still my responsibility to make sure the bill is paid
in a reasonable time. If for any reason my portion of my bill is not paid by my
Insurance, I further agree to make arrangements for prompt payment of the bill.
I have received a copy of ***Patient Financial Policy and Notice of Privacy Practices*** and
I understand my responsibility.

Signed _____ Date _____

Note: An Assistant surgeon may be used during your surgery. This fee will be billed to your insurance company; you ARE NOT responsible for any portion of this fee the insurance company does not pay. Any payment on the assistant surgeon's fee will not be credited to the primary surgeon's fee under any circumstances.