PRINT

John M. Peric, M.D.

2701 W. Alameda Ave Suite 2 02, Burbank, CA 91505 | Phone: 818.570.0542 | Fax: 818.558.1156

Eligibility Waiver & Understanding of Financial Responsibility

I,_____(the patient), parent, legal guardian, and/or subscriber hereby attest that the Patient is an "Eligible" member of_____insurance plan as of this date of service. I further hereby attest and agree that should it later be determined that the patient is ineligible for medical insurance. I understand that I am liable for all charges for services. Payment is required within 30 days of receiving a bill from this medical provider and/or physician. I further understand that I am liable for all non-covered services and that payment for non-covered services is due and payable at the time of service.

In the event that eligibility cannot be verified, services will be provided with the understanding that if the insurance coverage is not effective, I will be billed and held financially responsible for any/all services rendered.

I have read the above and understand my financial responsibility for services rendered and hereby affix my signature as acknowledgement of this understanding.

_____ _____

Patient's full name Patient's date of birth

X _____ _____ _____

Patient or Parent/Guardian Signature Print Name Date

_____ _____

Insurance certificate number Name of Insurance carrier

Consent for Treatment, Billing, and Release of Information

I consent to medical and/or surgical treatment including but not limited to x-rays, laboratory tests, and other diagnostic studies as is necessary.

I agree that to the extent necessary to determine liability for payments and to obtain reimbursement, this medical provider may disclose portions of the patient's record, including medical records, to any person or corporation which is or may be liable for all or any portion of the charges incurred. This may include but not be limited to insurance companies, health care service plans, or worker's compensation carriers.

I understand that any employer requested medical care, including but not limited to pre-placement physicals, drug testing, information for OSHA and MSHA standards or work-related injury or illness will be directly disclosed to requesting employer.

I irrevocably assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that a charge of $35.00 will be applied to all returned checks for insufficient funds.

I have reviewed the **Notice of Privacy Practices**.

I have read and understand the above:

X _____ _____ _____

Patient or Parent/Guardian Signature Print Name Date