SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

1. **INSURANCE:** I request that payment of authorized insurance benefits be made on my behalf to All Star Health for services furnished to me by All Star Health. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. All Star Health accepts the charge determination of the insurance carrier as the full charge; I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the insurance carrier.

2. **RELEASE OF INFORMATION**: All Star Health may disclose all or any part of my medical record and/or financial ledger to any person or corporation which is or may be liable or under contract to All Star Health for reimbursement for services rendered, and any health care provider for continued patient care.

3. **OTHER INSURANCE**: I understand that All Star Health maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that All Star Health has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by All Star Health if I belong to a plan that does not appear on the above-mentioned list.

4. **NON-COVERED SERVICES**: I understand that All Star Health contracts with health care service plans, (i.e., HMO's, PPO's). Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered.

Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnished to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with All Star Health to obtain necessary health care service plan authorizations.

5. **FINANCIAL AGREEMENT**: I agree that in return for the services provided to the patient by All Star Health, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to All Star Health for payment. If an account is sent to an attorney for collections, I agree to pay collection expenses and reasonable attorney fees as established by the court. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to All Star Health. If my insurance company or health plan designs co-payments and/or deductibles, I agree to pay them to All Star Health. However, it is understood that the undersigned and/or the patient is primarily responsible for the payment of the bill. I also agree that if I have to miss a scheduled appointment without giving at least 24 hours notice, I can be charged a $35.00 cancellation fee.

6. **PRIVACY PLAN**: I agree that I have been given the opportunity to read and receive a copy of the All Star Health agreement. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

____
Patient or Guardian Name (print)

____ _________________________
Patient or Guardian Signature ** Date

** If an authorization is signed by an individual's personal representative, the representative's authority is based on:
____ (e.g., state law, court order, etc.)