SIGNATURE FOR INSURANCE AND PRIVACY NOTICE

I have read and understand the office policy and agree to abide by its guidelines. I _____, have insurance coverage and assigned directly to Dr. Michael J. Reid, M.D. all medical and/or surgical benefits including any major medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorized the Doctor to release all information necessary to secure the payment of my benefits.

Patient, please be aware that at the time of verifying your insurance we are performing a courtesy. If for some reason the information or benefits changes in your insurance, it's ultimately the patient's responsibility to know their benefits and what it covers.

Please note that we will bill your insurance and any left over responsibility from the deductible and/or co-insurance will be sent home in a monthly statement.

***I _____am also aware that if I have a deductible or a co-insurance and if it does apply to my office visits and also apply to any procedures here in the office (skin, testing, breathing test,etc…) that I am responsible for this money due to the office of Dr. Michael J. Reid for each visit. ***

_____ _____

Signature of Responsible Party **Date**

I have also received Dr. Micahel Reid's Notice of privacy form and was provided a copy of this and understood my rights as a patient of Dr. Michael J. Reid.

_____ _____

Signature of patient or responsible party Date