Peter E. Franklin, M.D.

PATIENT'S NAME _____

This is to remind all Dr. Franklin's patients, that although you are covered by insurance, it is **YOUR** responsibility not that of the insurance company, for payments of all non-covered services rendered in our office.

Please review your insurance coverage.
It is up to you to know what portion you will be responsible for. For example:

- Non-covered services vaccinations, etc.)
- Which medical lab your insurance is networked with (Quest, Hunter, etc.)
- Referrals to specialists, if authorization is required.

I understand and agree that (regardless of insurance status), I am ultimately responsible for the balance of my account for all services rendered on my behalf and that of my dependents. I hereby authorize Peter E. Franklin, M.D., to collect all insurance benefits otherwise payable to me for services rendered. I also authorize Peter E. Franklin, M.D. to release any information for serves required to secure payment of benefits by my insurance company(s).

I authorize the use of this signature for all insurance claim submissions.

_____
Signature of Responsible Party

Date _____