Consent For Treatment – Assignment Of Benefits

I authorize Drs. Caudelle and Wilson (hereafter referred to as provider) to provide me (or my child) reasonable and proper medical, visual and optical care by today's standards.

I authorize release of any information required to provide necessary medical care or in processing insurance claims. I acknowledge that I am responsible for treatment costs where my insurance is not accepted by the provider or for charges not covered by my insurance policy when the provider has filed my insurance as a service to me.

I hereby authorize my insurance benefits to be paid directly to the provider. In the event that my insurance company establishes an internal *usual and customary fee schedule,* I understand that I am responsible for any difference that is not paid*.

Full payment is due in 90 days. If my insurance fails to pay within 90 days for any reason, I will be expected to remit payment in full. I further agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all cost of collecting monies owed, including court costs, collection agency fees, attorney fees and any other reasonable fees incurred. I also understand all co-payments or deductibles are to be paid at each visit and that filing of secondary insurance coverage is my responsibility.

*Exceptions: Medicare, Medicaid, medigap and certain HMO's and PPO's.

I have read the above information and have had a chance to ask questions regarding these policies and all my questions have been answered to my satisfaction.

Patient or Parent Signature Date

Printed Patient Name

INT. DATE INT. DATE INT. DATE INT. DATE INT. DATE INT. DATE