Assignment of Benefits Form and Lien Interest Form

Balogun & James Wellness
5555 W. Loop South, Ste. 205
Bellaire, TX 77401

Financial Responsibility

I have read, understand, and agree to *Balogun & James Wellness* Financial Policy. I understand that charges not covered by my insurance company, 3rd party insurance, private insurance, Medicare, Medicaid, and any other health/medical plan as well as any applicable co-payments and deductibles are my responsibility. All professional services rendered are charged to the patient are due at the time-of-service, unless other arrangements have been made in advance by either the patient or his/her health insurance carrier which will require necessary forms be completed, filed and approved by *Balogun & James Wellness*. A photocopy of this Assignment shall be considered as effective and valid as the original.

Assignment of Benefits

I hereby irrevocably assign all medical benefits to which I am entitled under Texas Statutes for medical services provided by *Balogun & James Wellness*. I hereby authorize and direct my insurance company, 3rd party insurance, private insurance, Medicare, Medicaid, and any other health/medical plan to issue payment check(s) directly to *Balogun & James Wellness* for medical services rendered to me and/or my dependent(s). I further understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize *Balogun & James Wellness* to furnish and/or release any information necessary to insurance carriers concerning my treatments and/or illness, to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim. This order will remain in effect until revoked by me in writing. A photocopy of this Authorization is to be considered as effective and valid as the original.

Request for Services

I have requested medical services from *Balogun & James Wellness* on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I also understand that I will be responsible for *Collection fees, Attorney fees and/or Court costs* should it become necessary to take legal action to collect for the medical services rendered. I further understand that fees are due and payable on the date that services are rendered and have agreed that in consideration of not paying immediately, hereby give *Balogun & James Wellness* a lien or interest in money that may be paid to myself and/or my dependent(s) by my insurance company, 3rd party insurance, private insurance, Medicare, Medicaid, and any other health/medical plan.

Patient's Name	Patient's Signature	Date