STRICKER C. MAYS, M.D.
SUE GRIFFIN,ARNP/WHNP-BC
131 E. Redstone Ave. Ste. #109
Crestview, FL 32539

STATEMENT FO FINANCIAL RESPONSIBILITY
AND
ASSIGNMENT OF BENEFITS

Dr. Mays and Sue Griffin are please to file insurance claims; however **the patient or guarantor is responsible for payment for all services provided.** Authorization or pre-certification of a procedure does not guarantee payment by your insurance company. Since insurance companies determine amount of payment after claims have been submitted, we cannot know in advance how much your insurance will pay.

Please initial each paragraph and sign below.

_____ I have provided Dr. Mays and Sue Griffin with the most current insurance information available.

_____ I Authorize Dr. Mays and Sue Griffin to release to my insurance carrier(s), or their representatives, any information from my medical records needed to process insurance claims.

_____ I acknowledge my financial responsibility for payment for all services provided by Dr. Mays and Sue Griffin including those services which my insurance carrier considers not covered, not medically necessary, or incidental to another procedure.

_____ I agree to pay charges promptly upon receipt of first bill. If I am experiencing financial hardship, I will request approval of a payment plan at time of service. I understand that unpaid bills may be turned over to a collections agency 90 days after date of service.

_____ _____

Patient Signature Date