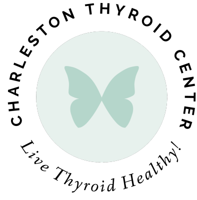

Patient Financial Responsibility

I hereby authorize The Charleston Thyroid Center to apply for benefits on my behalf for covered services rendered by the practice. I also assign my benefits and request that all payments from my insurance company be made directly to Charleston Thyroid Center. I agree to assume responsibility of full payment pending any remaining balance that is not covered by said insurance company including fees and services that are not covered by my medical insurance.

I certify that the information I have reported with regard to my coverage is correct. I further authorize Charleston Thyroid Center to release to said insurance company and its agents any information related to this or any claim.

I understand that if I do not pay my balance, despite statements being sent to me, within the timeframe specified by company policy, my case could be turned over to a collections agency. At that time, any fees associated with this service will be added to my account.

______________________________________ **DATE** ________________________