indianapolis
sinus center

CONDITIONS OF SERVICE

USE AND DISCLOSURE OF INFORMATION: I hereby acknowledge that **Indianapolis Sinus Center** gave or offered me a copy of the Notice of Privacy Practices. The Notice of Privacy Practices explains how my information may be used or disclosed.

ASSIGNMENT OF MEDICARE AND/OR THRID PARTY INSURANCE BENEFITS: I agree that any benefits of any type arising out of Federal or State program or any policy of insurance for me, or any other party liable to me, are hereby assigned to **Indianapolis Sinus Center** or treating healthcare provider that renders for which an assignment is applicable. I understand that I am financially responsible to **Indianapolis Sinus Center** or treating healthcare provider for charges not covered by this authorization. I certify that the information given by me is accurate and complete.

FINANCIAL AGREEMENT: I agree, whether I sign as agent or patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account of **Indianapolis Sinus Center** and treating healthcare provider in accordance with the regular rates and terms of said providers. Should the account be referred for collection I understand that I am responsible for reasonable attorney fees and collection expenses. All delinquent accounts may bear interest at the legal rate. I recognize that all treating healthcare providers furnishing services to the patient may submit a separate statement or account from/for each health care provider.

MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ THE ABOVE INFORMATION AND AGREE TO ACCEPT ITS TERMS.

Patient Signature: _____ **Date:** _____

(If the patient is a minor or unable to sign, the person taking responsibility must sign below)

Signature: _____ **Date:** _____

Relationship: _____