**Financial Agreement & Treatment/ Insurance Authorization/ Photo Permission**

*(Please initial next to each paragraph & sign below.)*

**\_\_\_\_\_** I authorize the treatment from Steven C. Patching and agree to pay all fees and charges promptly, in the event that my insurance company does not cover my treatment and payment is denied. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. In the event legal action should become necessary to collect an unpaid balance, I agree to pay reasonable attorney’s fee or other such cost as the court determines proper.

**\_\_\_\_\_** I authorize insurance payments to be paid directly to Dr. Steven C. Patching; however, I understand that the bill is my responsibility and payments will not be delayed or withheld because of any insurance coverage or pendency of claims. (A copy of this assignment is as valid as the original.)

**\_\_\_\_\_** I authorize the release of all medical information necessary to process insurance claims regarding the above named patient.

**\_\_\_\_\_** I authorize permission to take my photo for before and after purposes. ***(FOR BARIATRIC PATIENTS ONLY)***

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please print your name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to Patient if not self:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_