Direct Billing Consent, Authorization and Acknowledgement

Consent to Collect and Exchange Personal Information: I authorize my health care provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer/plan administrator and their service providers for the purposes of assessing my claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud/plan abuse. I confirm I have consent from the primary insured plan member (if not myself) to collect, use and disclose any personal information about them for the same reasons as stated a bove.

I hereby authorize my health care provider to directly bill my insurance company on my behalf for services rendered.

I acknowledge that if my claim is not paid in whole/part or is not paid directly to the health care provider whole, that I will pay any balance owing immediately after treatment. If the health care provider needs to wait on payment details, pay ment of the balance must be paid within two weeks of Claim Summary and before any future appointments can be booked.

______________________________ ______________________________ __________________

Print name Signature Date