FINANCIAL RESPONSIBILITY STATEMENT

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Eriksen's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Eriksen's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, against Dr. Eriksen's recommendation, my account balance will be immediately due and payable.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____

If not patient, please print name of responsible party

AUTHORIZATION, ASSIGNMENT, AND RELEASE

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. I agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
4. This Authorization for Assignment will be in continual effect until revoked by both parties.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____

If not patient, please print name of responsible party