

# Elements Health- DIRECT BILLING AGREEMENT

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Insurance Company (please provide all cards to staff for confirmation):

1. My Insurance Company: \_\_\_\_\_

Card # \_\_\_\_\_

2. Secondary Insurance Company (if any): \_\_\_\_\_

Card #: \_\_\_\_\_

Spouses Name (if applicable): \_\_\_\_\_

**Coordination of Benefits (COB)** is a standard practice among benefit carriers in Canada. COB applies to people with more than one plan.

Are you covered under more than one health benefit plan?  no  yes

Are you claiming under your spouse's plan?  no  yes

**IF YOU ANSWERED "yes" to BOTH ABOVE** we must submit the claim to your own plan first. If both spouses have health benefit coverage, children must claim under the plan of the parent with the earliest birthday (month and day NOT the year).

**Elements Health** agrees to submit billings on your behalf via your insurer online system as applicable.

I hereby agree to the following:

1. Elements Health may submit on my behalf for services rendered.
2. I understand that unless payment can be verified on the date of my service, I will be required to pay for the services I receive.
3. I will be **notified promptly of any uninsured portion and agree to pay any balance owing immediately**. Unpaid balances after 90 days will be sent for 3<sup>rd</sup> party collection.
4. I will notify Elements Health of any changes to my plan immediately.
5. Elements Health may discontinue direct billing at any time.
6. This agreement applies to all insured members on the above listed cards.

\_\_\_\_\_  
Patient/Cardholder Signature

\_\_\_\_\_  
Staff Authorization (Print Name)