Peter E. Franklin, M.D.

PATIENT'S NAME
This is to remind all Dr. Franklin's patients, that although you are covered by insurance, it is YOUR responsibility not that of the insurance company, for payments of all non-covered services rendered in our office.
Please review your insurance coverage.
It is up to you to know what portion you will be responsible for. For example: • Non-covered services vaccinations, etc.)
 Which medical lab your insurance is networked with (Quest, Hunter, etc.) Referrals to specialists, if authorization is required.
I understand and agree that (regardless of insurance status), I am ultimately responsible for the balance of my account for all services rendered on my behalf and that of my dependents. I hereby authorize Peter E. Franklin, M.D., to collect all insurance benefits otherwise payable to me for services rendered. I also authorize Peter E. Franklin, M.D. to release any information for serves required to secure payment of benefits by my insurance company(s).
I authorize the use of this signature for all insurance claim submissions.
Signature of Responsible Party
Date