DISC SURGERY CENTER AT NEWPORT BEACH
Appeal Authorization and Insurance Payment Agreement

Patient Name: _____ DOB: _____

Insurance Company: _____

ID # _____

Date of Service: _____

Per my insurance company, the payment for services provided to me by Diagnostic and Interventional Surgical Center on the date above may be mailed to me, the member.

I agree to endorse and forward all checks I receive from my insurance carrier to Diagnostic and Interventional Surgical Center as payment for the services provided to me by them.

If I fail to do this once the claim has been processed, I agree to pay the full invoice amount to Diagnostic and Interventional Surgical Center.

I will be responsible for any deductible amount applied to my charges by my insurance company.

In the event that my insurance company denies or low pays any medical services performed, I (_____) hereby authorize Diagnostic and Interventional Surgical Center to file an appeal on my behalf.

Should my insurance company fail to pay at the reasonable and customary rate or deny payment for services, I understand that I will be financially responsible for the invoice amount.

Thank you,

_____ _____
PATIENT SIGNATURE DATE SIGNED

Revised 10/2012