

Effective Date: 10/25/11

CONSENT TO ASSIGNMENT OF BENEFITS AND PROMISE TO PAY

Benefits to Physicians:

I hereby assign all of my rights to insurance benefits and instruct my insurance company to make payments directly to Allergy and Asthma Clinic of Wyoming, LLC, and/or its physicians for the benefits provided.

Promise to Pay:

I understand and agree that I am responsible to pay for all services provided to me by Allergy and Asthma Clinic of Wyoming, LLC, and its staff. If I fail to pay for the services when they are rendered or on a signed agreed payment schedule, I will be responsible for all costs of collections, including but not limited to, interest at the rate of one and half percent (1.5%) per month or eighteen percent (18%) per year, court costs and fees, attorney fees, and a collection fee of thirty five percent (35%) of unpaid balance assigned for collection.

Date

Patients Signature

Signature of the Patient's Representative
(Required if the patient is a minor or an adult unable to sign:

Relationship