DARRELL CORBEN, M.D.
441 DEGUIGNE DRIVE, SUITE 1
SUNNYVALE, CA 94085

Registration Form Agreement

I request that payment of authorized insurance benefits be made to the physician/supplier for any services furnished by that physician/supplier. I authorize any holder of medical information regarding myself to be released to the insurance carrier, and or its' agent, if it is information needed to determine benefits or payments. I understand that my signature requests that payment be made, and authorizes a release of medical information necessary to pay the claim. If, at the time of service, I state that I have valid insurance coverage, but later, for whatever reason, I was in fact not covered, I acknowledge and agree that I am responsible for the entire fee for the provided services. In addition, if the insurance carrier, or its' agent, determines that a service was not medically necessary, but the physician/supplier believes that it was, then I agree that I am responsible for the entire fee. Also, if the insurance carrier determines that a provided service was, or is, a non-covered benefit, I agree that I am responsible for paying the associated charges.

In Medicare assignment cases (if accepted), the physician/ supplier agrees to accept the charge of the Medicare carrier less co-insurance and deductibles.

In the event that payment for services provided become 'past due', and no alternative payment agreement has been arranged with the billing office, the total balance due will be assessed a one-time arrears charge of 35%, and will then be forwarded to the Collections Department for payment.

SIGNED INSURED OR GUARDIAN

DATE

PRINTED NAME