



Benefits Assignment and Financial Responsibility

I, in consideration of the professional services rendered to me by **Vori Health**, voluntarily give consent for such treatment, and agree to the following:

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize **Vori Health** to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize the use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies. The information provided by me regarding health care coverage is true and accurate to the best of my knowledge.

ASSIGNMENT OF BENEFITS: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me, and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

UNDERSTANDING OF FINANCIAL RESPONSIBILITY: I acknowledge that a telehealth visit, conducted via audio or audio/video communication, is considered equivalent to an in-person office visit. I understand that if the telehealth visit meets all applicable requirements, it will be submitted to my insurance for processing. I further understand that I am financially responsible for any applicable costs, including copayments, coinsurance, deductibles, or any portion not covered by insurers or third-party payors.

I understand that such services rendered by **Vori Health** will require payment, and I accept responsibility for such payment. I hereby obligate myself to pay the account of Vori Health in accordance with the regular rates and terms of such payment, and guarantee payment within 60 days from receipt of first billing statement. I further acknowledge responsibility for payment of all deductibles, co-payments, or other fees not covered by insurers or third-party payors incurred by me because of services rendered. I understand that if I do make payment to my account within 60 days from receipt of the first billing statement that future appointments may be canceled until payment is received.

I hereby authorize any benefits due to me to be paid directly to Vori Health in accordance with this assignment. I certify that I am the patient, or a duly authorized general agent of the patient or guardian of the patient, if a minor, and am authorized to execute this document and accept its terms.