Nat Kuhn MD
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Authorization and Acceptance of Financial Responsibility

Regarding the treatment of

Name	

by Nathaniel (Nat) Kuhn, MD:

- I authorize payment of insurance benefits to Dr. Kuhn.
- I understand that my authorization does not guarantee payment or reimbursement by the insurance carrier.
- I agree that I am fully responsible for paying Dr. Kuhn for outstanding charges not covered by (or unreasonably delayed by) insurance including, but not limited to, co-payments, co-insurance, deductibles, non-covered services, claims rejected for any reason including lack of prior authorization or denial of medical necessity, late cancellation fees, charges for missed appointments, and same day/same charge duplication by different providers.
- I agree that I will be responsible for other charges related to any unpaid balance such interest and collection fees.

Guarantor:

Name	First	MI	Last				
Address				Apt #		Phone	( ) -
City		State		Zip		Email	
Signature	Signed: _____					Date: _____	

Co-guarantor (optional):

Name	First	MI	Last				
Address				Apt #		Phone	( ) -
City		State		Zip		Email	
Signature	Signed: _____					Date: _____	