PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

RELEASE OF INFORMATION:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature ______________________________ Date ________________

PAYMENT POLICY:

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. **For those patients, applicable copayments and deductibles will be collected.** We accept payment in the form of cash, check, or credit card. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. **In the event that your account must be turned over to collections, a $20 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy. A charge of $5 will be issued for all bills generated as a result of non payment at the time of your visit.**

When you decide that you do not need further services, please check with our billing department for balance/credits.

Patient or Responsible Party Signature ______________________________ Date ________________

MEDICARE PATIENTS ONLY:

IT IS YOUR RESPONSIBILITY TO LET US KNOW WHO YOUR PRIMARY INSURANCE IS!

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to the payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on your Medicare Card ______________________________ Date ____________

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over' we are required to keep a separate signature on file. I request the authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Thank you for choosing our office to assist in your care.