

Financial Authorization Form

Patient Name: _____ **Date of Birth:** _____

ASSUMPTION OF RESPONSIBILITY I obligate myself, assume financial responsibility and agree to pay upon demand to above named provider all charges for such services and incidentals incurred. Should the account be referred to an outside collection agency or attorney, I shall pay reasonable attorney fees and all collection expenses associated with the account. Even though insurance may be filed, I understand that all bills are payable upon receipt and that I, and not the insurance company, am responsible for the payment of all services.

COPAYMENTS I agree to be fully responsible for paying co-pays of set amounts at the time of physicians visit. Further, I understand that if my co-payment is a percentage, I will be responsible for payment immediately after insurance benefits have paid. This meaning that any bill received once insurance is paid will be due upon receipt. If co-payments or deductibles are not received within 30 days of the patient statement date, professional fees are due in the total amount of charges and payable in full from you.

NONCOVERED SERVICES I agree to be fully responsible for any care not paid for by my existing insurance coverage. I understand that payment is required in full at the time services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service.

WORKER'S COMPENSATION If your injury is work-related, we will need to verify worker's compensation eligibility with your employer prior to your visit.

YEARLY HEALTH CHECKS Periodic preventive health checks may or may not be covered under your health insurance policy; however, they may be required by your physician.

MISSED APPOINTMENTS In fairness to other patients and the doctor, we required at least 24 hours' notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice.

Please check one: <i>I have paid my insurance deductible for the calendar year</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

<p>SIGNATURE ON FILE I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Family Practice Center, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.</p>

<p>I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. Where benefits are assigned, the provider agrees to accept the charge determination of the healthcare carrier as the full payment, and the patient is responsible only for the deductible, coinsurance, and non-covered services as agreed by that patient's plan. Coinsurance and the deductible are based upon the charge determination of the healthcare carrier. I hereby authorize said assignee to release all information necessary to secure the payment.</p>

Signature: _____ Date: _____

I have read, understood, and agree to the above.

Signature: _____ Date: _____