RELEASE OF INFORMATION

By signing our release of information form, you provide us with the authority to release such information as is necessary to collect from insurance companies and other third party payers.

PATIENT RESPONSIBILITY

Balances after insurance are due within 30 days of the insurance payment, unless other satisfactory arrangements have been made with the clinic. Not all services are covered by all insurance companies. It should be understood that by accepting the service(s), the patient is responsible for payment regardless of the fact that insurance covers the service or not. The clinic cannot become involved with any third party liability matters and must always look to the patient/guarantor for payment of the bill.

OUTSTANDING BILLS

The clinic reserves the right to request deposits and payments for outstanding balances. Deposits will be based on the outstanding balance plus the patient's share of the bill for the new services to be performed.

HEALTHCARE LIENS

The clinic reserves the right to file healthcare liens against the patient and other responsible parties as is deemed appropriate to protect the clinic interest.

BAD DEBTS/ LEGAL ACTION

If the account is not paid in full or satisfactory arrangements made within the allowable time frame, the clinic reserves the right to refer the account to an attorney and/or a collection agency for the collection of the balance. I agree to assume responsibility for all charges incurred should collection of this balance become necessary including court costs and attorney's fee.

AUTHORIZATION FOR TREATMENT

I hereby authorize the physicians of the facility who are in charge of the care of the individual named above, or any nurse practitioner, physician's assistant under their supervision and other allied health professionals to administer treatments as are deemed necessary or advisable in the diagnosis of my care.

RELEASE OF RECORDS

I hereby authorize other healthcare providers who are or have been involved in my care to release my medical records to this facility/unit.

I hereby authorize the facility/unit to transfer copies of my medical records to any other healthcare provider that is involved with my care while I am a patient of the facility or to whom I may be transferred to during my course of treatments.

I hereby authorize the facility/unit, any insurance company, claims or benefit administrator, pre-payment organization, governmental agency or health care provider to obtain information and provide information (including medical information and financial records) necessary to process an application for insurance, Medicare or Medicaid benefits, to determine the availability for benefits that may be available and to obtain required pre-authorizations and re-authorizations.

The administrative and management welcomes the opportunity to discuss any aspect of the authorization policy. We appreciate your confidence and strive to provide quality healthcare.

I have read the *Financial Policy/ Policy Statement* and understand regarding above.

_____ _____

Patient/Guarantor Date

_____ _____

Witness-Staff Employee Date