WASHINGTON COUNTY INTERNAL MEDICINE
501 Sparta Road, Suite F
Sandersville, GA 31092

Patient Payment/Assignment of Benefits Agreement

Thank you for allowing us to serve you. We are committed to providing our patients with the best possible medical care in addition to prompt and courteous service. Our services are based on medical necessity. As a courtesy to our patients, we will file insurance claims on your behalf to the carrier(s) that you provided to us on your Patient Information Form. However, some insurance carriers do not reimburse for certain procedures and/or diagnosis. We will have you sign a *Notice of Likelihood of Medicare Denial* if we believe Medicare will deny any services we provide you. In the event a claim is filed and denied for charges not covered, you are responsible for all denied charges.

We ask that you sign this agreement for all services rendered

I *(print name)* _____, have received instructions that certain procedures and diagnosis may not be covered by my insurance carrier. I further agree to reimburse **Washington County Internal Medicine** for all charges related to services rendered.

Insurance claims are filed as a courtesy to our patients. Patient co-payments and/or patient responsibilities are due at the time service is rendered.

We ask that you sign this agreement so we may file your insurance

I, the undersigned, realize that all medical and surgical charges incurred are my responsibility and payable by me regardless of what my insurance pays. I hereby authorize and direct my insurance carrier(s), including Medicare, to pay directly to **Washington County Internal Medicine** any benefits due under my insurance plan. I agree to pay the balance of expenses not paid under this plan, including deductibles and co-payments. I authorize my physician to release to my insurance company any medical information necessary to process my claims.

.

Authorized Signature: _____ Date: _____