CHABOT FAMILY ASSOCIATES, INC.
19845 LAKE CHABOT RD, #205
CASTRO VALLEY, CA, 94546
PH: 510-582-6424 FAX: 510-582-6462

Authorization for Claims Payment and Reviews

1. **Assignment and Coordination of Insurance Benefits** - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Chabot Family Associates, Inc. and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Chabot Family Associates, Inc. the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

2. **Unauthorized, Non-Covered, or Out of Plan Services** - I understand if my Insurance Plan(s) does not consider any of the outpatient visit or any service rendered during those outpatients visit a covered service or has not authorized this service, they will not pay for the service rendered during the outpatient visit. I agree to be fully responsible for payment to Chabot Family Associates, Inc for any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge. In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance. Chabot Family Associates, Inc. is not responsible for the accuracy of insurance information your provide, in case we are not able to determine eligibility of services rendered and plan participation prior to your outpatient visit, you will be responsible for any part of the services not covered by the insurance plan.

3. **For Medicare Recipients Only** - I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Chabot Family Associates, Inc and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. For Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

4. **Residents, Interns or Medical Students-** I understand residents, interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of the Chabot Family Associates' education programs.

5. **CO-PAY and ANY Past Due Patient Amount** – I understand that Co-Pay and any past due patient amount are due at the time of the Visit.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Chabot Family Associates. *I understand and agree this document will remain in effect for all future outpatient or physician office visits to Chabot Family Associates, unless specifically rescinded in writing by me.*

Patient / Parent or Guardian Signature: _____

Date: _____

Relationship to Patient: _____