

**Authorization and Financial Agreement Assignment of Benefits**

I certify that my insurance coverage is correct as I have reported it to New Medical. If at any time my insurance changes, I will notify the practice. I hereby authorize New Medical to submit claims on my behalf for services rendered by any and all providers affiliated with this practice, and request that payment from my insurance company be made directly to New Medical.

**Authorization to Release Information:**

I authorize the release of any necessary information to my insurance carrier regarding the services provided by New Medical. I permit it a copy of this authorization to be used in place of any previous documents and understand it is valid until revoked by me in writing.

**Financial Responsibility:**

* I agree to pay all self-pay charges, copayments and deductibles at the time of service. A $15.00 Fee for Non-Payment of Co-Pays/Deductibles will be charged in addition to my co-pay if I am unable to pay my copay at the time of service.
* I agree to provide my current insurance ID at every appointment, if requested.
* I understand if claims are denied due to eligibility status, an invalid medical group, invalid Primary Care Physician or any other reason, I will assume full responsibility for all charges incurred by myself and my dependents. Additionally, I will be financially responsible for any non-covered benefits, deductibles and every additional invoice/bill sent after the initial invoice/bill I could be charged a $15.00 returned check fee. It is my responsibility to understand my insurance benefits and coverage plan.
* Form Completion/Photocopying: There will be a charge of $15.00 if you require a duplicate for a sports physical or single page school form. Forms greater than one page that are not received and completed at the time of visit (DMV, Disability, FMLA, etc) will be $25.00. Copies of your medical record will be a minimum charge of $15.00 and then 25 cents per page. Letters written by the provider will start at a minimum of $25.00.
* I understand that nothing herein relieves me of the primary responsibility to pay for medical services provided. My insurance policy is an agreement between myself and my insurance company and I am responsible for understanding and obtaining coverage information.
* I agree that all bills are due when rendered and I agree to pay upon receipt. I realize that any collection efforts add unnecessarily to the cost of my care.
* I am willing to work with the office and my insurance company as necessary or requested, to assure timely processing of claims submitted on my behalf.
* In the event that my account shall be referred to collection, I agree to pay and be responsible for the amount of such bill together with any and all collection costs.
* No Show and Cancellation Policy: We sincerely request that 24-hour notice when cancelling or rescheduling an appointment, to avoid a $35.00 no show fee.
* I choose to receive communication from New Medical by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. I understand that such emails and texts may not be secure and there is a risk that they may be read by a third party.
* Medicare Beneficiaries: I request that payment of authorized Medicare benefits be made to New Medical. I authorize any holder of medical information about me to release to CMS and its agents my information needed to determine these benefits or the benefits payable for related services.

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(Signature of Responsible Party)

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
(Printed Name of Responsible Party)