Valley Primary Care Office / Insurance Policy

(Please initial the following section: please sign and date the bottom)

Insurance Authorization:

_____ I hereby authorize *VALLEY PRIMARY CARE* to furnish to specified insurance company(s) all information which the insurance company requests. I also hereby assign *VALLEY PRIMARY CARE* all money to which I am entitiled for medical and/or medical expenses related to the services rendered.

_____ I understand that I am financially responsible to *VALLEY PRIMARY CARE* for any charges not covered by this assignment. I fully agree in the event of non-payment to bear the cost of collection and/or court costs and reasonable fees, should this be required.

_____ In order to control your cost of billing *VALLEY PRIMARY CARE* requests that all charges for office visits be paid at the tme of your visit. It is your responsibility to pay any deductible amount, co-insurance, co-pay, or any balance not paid by your insurance.

Office Policy:

In order to accommodate the needs and requests of our patients we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of each plan. Each one has different stipulations requiring how often services may be rendered and even more importantly, where those services may be performed. Even within the same insurance company plans may differ depedning upon what type of contract you have. Providing quality care for our patients is our primary concern. We are more than willing to provide that care within your insurance limitations. Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently order services, such as lab work or hospitalization, that are not covered benefits we or the medical facility will have no choice, but to bill you directly for these charges. Payment for these charges is then your responsibility. With your cooperation and help, you should be able to receive all benefits offered to you, and we will be able to concentrate on caring for your medical needs.

I have read and undersatnd the Office Policy and Insurance Authorization stated above and agree to accept the responsibility as described

_____ _____

Patient/Responsible Party Signature ***Date***