Financial Policy

Name:_____ Date of birth:_____ Date completed:_____

I have received and reviewed Financial Policy of AVP Primary Care, PLLC.

Responsibility for Payment

I understand that I, personally, am financially responsible to AVP Primary Care, PLLC for charges not covered by the assignment of insurance benefits.

Assignment of Insurance Benefits

I hereby assign, transfer, and set over directly to AVP Primary Care, PLLC sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to me. I authorize AVP Primary Care, PLLC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to AVP Primary Care, PLLC. I authorize AVP Primary Care, PLLC to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

Release of Information

I hereby authorize the and direct to AVP Primary Care, PLLC to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

Collection fees

I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

Please sign and date below:

_____ _____

Signature of Patient / Legal Guardian Date