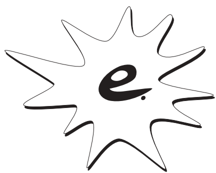

The Endocrine Clinic, P.C.

Financial Policy/Authorization Form

PATIENT NAME: ______________________________

SOCIAL SECURITY #: ____________________ **DATE OF BIRTH:** ____________

I request that payment of authorized Medicare/Medicaid and/or other health insurance benefits be made on my behalf to the providers of The Endocrine Clinic, P.C. for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) or my designated insurance company any information needed to determine these benefits or the benefits payable for related services.

I agree that for and in consideration of acceptance by The Endocrine Clinic for services rendered to me, hereby obligates me, and I assume financial responsibility and agree to pay *at each time of service* to The Endocrine Clinic all charges for such services and incidentals incurred by me, unless otherwise specified under my contracted PPO/HMO agreement. If I am covered under Medicare Part B program, I agree to pay my annual deductible and 20% copayment *at each time of service*, unless covered by another supplemental policy. Should the account be referred to an attorney for collection, I shall pay reasonable attorney fees and collection expenses, as well as a 40% service charge (minimum of $15.00). I also understand and agree to pay a $20.00 service charge for any returned checks. I understand that all bills are payable upon presentation and that I, not the insurance company, am responsible for the payment of all services. *For your convenience, The Endocrine Clinic accepts cash, checks, debit cards and all major credit cards.*

I hereby authorize The Endocrine Clinic, P.C. to release sociological and medical information officially acquired in the course of examination and treatment for the purpose of filing for insurance benefits and other financial coverage. I understand that it is my responsibility to inform The Endocrine Clinic of any changes in my insurance, address & phone numbers both personally and employment related.

I also understand that if I am enrolled in a managed care insurance plan, I am responsible *at each time of service*, for informing The Endocrine Clinic of any special requirements of my insurance plan, including but not limited to, how often services may be rendered or where those services may be performed. If I do not inform The Endocrine Clinic of special requirements in my contract, and The Endocrine Clinic subsequently orders services that are not covered, such as lab work or hospitalization, The Endocrine Clinic or the selected medical facility will bill you directly for those charges. *Payment for those charges is then your responsibility.*

I have read, understand and approve all of the information provided to me above.

______________________________ ____________________

Patient's Signature **Date**

(or Custodial Parent/Legal Guardian if Patient is a Minor)

FPS#40138