RELEASE INFORMATION- I authorize the release of medical information to my primary care, referring, or consulting physicians. We will only send medical information to the physicians that are listed on your information sheet. I also give permission to give medical information to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to physicians.

PAYMENT POLICY - Co-pays and deductibles are due at time of service for those insurance policies we are contracted with. For those insurance policies that we are not contracted with, we will gladly file your insurance claim however; payment will be requested at time of service. If your insurance requires a referral, it is the patient's responsibility to make sure we have the referral before your appointment time. It is your responsibility to ensure that we are contracted with your insurance. We are not contracted with Medicaid, Wellcare, AmeriGroup or any other insurance relating to Medicaid. Private pay patients will be required to pay in full at time of service. There is a $35.00 return check fee on any check that is returned to our office.

MEDICARE - We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying 20% co-payment at the time of service. We will bill secondary/supplemental carriers. However, in the event that the secondary carrier does not pay within 60 days, patient will be billed.

NO-SHOW APPOINTMENTS - An appointment confirmation call will be made 1 to 3 days prior to your scheduled appointment date and time. Due to the increased volume of no-show appointments we will charge you a $25.00 fee to your account. If this is not paid it will be turned over for collections. It is the patient's responsibility to inform our office of any changed phone numbers and/or addresses.

**** If you do not pay your bill or attempt to make payment arrangements, you will be turned over to collections!

By signing below, I agree that I have read all of the above information and understand.

_____ _____

Patient/Guardian Signature **Date**