Heart and Family Health Institute

Financial agreement

Financial acknowledgement for Private Pay Patients or Patients without Insurance:

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

Signature of Patient or Personal Representative **Date**

Assignment and Authorization of Benefits for Patients with Insurance:

I hereby assign all medical and /or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to the practice. I understand that I am financially responsible for all charges, co-payments, co-insurance and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

Signature of Patient or Personal Representative **Date**

Medicare Lifetime Authorization

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to Heart and Family Health Institute.

Patient Initial: _____

I request this authorization also apply to all other insurance.

Patient Initial: _____