Patient Name (print) _____ DOB_____

OUR FINANCIAL POLICY

Our provision of care to you will result in a bill for our services. Following is a statement of our Financial Policy, which we request you read and sign prior to your treatment. In addition all patients must provide basic registration and insurance information before seeing the physician.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE, UNLESS WE ARE BILLING YOUR INSURANCE FOR YOU, IN WHICH CASE, ANY APPLICABLE CO-PAYMENT OR DEDUCTABLE IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA OR MASTERCARD.

REGARDING INSURANCE

We ask that you show us a copy of your medical insurance card at the time of each visit so we can set up the correct billing information. As a courtesy we will bill your insurance carrier for the charges which the company has agreed to pay. You are responsible for any amounts not covered by your insurance, including co-payments and deductibles. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If you do not inform us of any special requirements or guidelines in your policy, such as second opinions, pre-authorizations, preferred providers and covered and non-covered services, and we subsequently perform or order items or services that are not covered we will have to bill you directly for those charges. If your insurance company has not paid your account within 45 days, the account automatically becomes your responsibility and will become due immediately. Please be aware that some of the items or services provided may not be covered or may not be approved for payment under your policy, but have been deemed to be in your best interest bye your Physician.

RESPONSIBILITY

If you are 18 or older, you are legally responsible for your own account, regardless of who you life with, who has the contract with the insurance company or who claims you as a tax deduction. If the patient is under 18, both parents, despite divorce or other separating arrangements, or the legal guardian of the patient, are responsible for payment.

I have read the Financial Policy and understand and agree to its terms.

X_____ Date:_____

Signature of patient or responsible party.

MEDICARE – ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare benefits be made on my behalf to Cedar Medical Specialties; PLLC ("Cedar"), for any services furnished me by any physicians or other providers employed bye Cedar. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. I understand that Cedar accepts the charge determination of the Medicare carrier as the full charge for all authorized Medicare benefits, and I am responsible only for the deductible, coinsurance, and non-covered services. I understand that coinsurance and deductible are based upon the charge determination of the Medicare Carrier and all co-payments and deductibles are due at time of service I have read the assignment of benefits and agree to its terms.

X_____ Medicare #_____ Date:_____

Signature of patient or responsible party.

PRIVACY POLICY

I acknowledge receipt of the Medical Record Privacy Policy.

X_____ Date:_____

Signature of patient or responsible party.