Valley Internal Medicine, LLC

Authorization to Release/Receive Medical Information • Assignment of Benefits

We strongly feel that all patients deserve from us the very best medical care that we can provide. Furthermore, we feel that everyone benefits when definitive financial arrangements are agreed upon. For your convenience we have prepared this material to acquaint you with our policy.

It is important that we keep our patients fully informed at all times, therefore, we ask that you please make note that services rendered to you are billed to your insurance as a courtesy. Any charges not resolved by your insurance company are your responsibility.

Please read and sign the following:

1) **I authorize this office to release or receive information necessary to expedite insurance claims.**
2) **I hereby authorize this office to bill my insurance company directly for their services.**
3) **I authorize payment directly to this physician of any insurance benefits otherwise payable to me.**
4) **In the event I receive payment from my insurance carrier. I agree to endorse any payment I receive over to my physician for which these fees are payable.**

I understand that I am directly and fully financially responsible to the treating physician for charges not covered by my insurance. I further understand that such a payment is not contingent on any settlement, judgment or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay my balance in full, or there is no payments made within 60 days, it is my responsibility to pay the outstanding balance on my account in full.

I also understand that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection efforts, including filing fees as well as attorney's fees.

I understand there will be a $30.00 charge on all returned checks made to this office.
(In the event that a check issued to this office has been returned, you will be notified immediately. You will then have 10 days from the date that you are notified to pick up the check/returned check fee. Failure to comply will result in turning the instrument over to the District Attorney.)

A photo static copy of these authorizations and agreement shall be as valid as the original.

Printed Name of Patient: _____

Patient Signature: _____ Date: _____