Signature on file, Assignment of Benefits, Financial Agreement

Initial

_____ 1. **RELEASE OF INFORMATION**: Dr. John R. Pedrotty M.D. may disclose all or any part of my medical record and/or financial ledger to any entity which is or may be liable or under contract with Dr. John R. Pedrotty M.D. for reimbursement of services rendered, and other services related to my continued medical care including but not limited to: insurance carriers, referring physicians, anesthesiologists and transcription agencies.

_____ 2. **INSURANCE**: I understand that Dr. John R. Pedrotty M.D. will bill my insurance carrier as a courtesy to me. I understand that it is **MY RESPONSIBILTY** to verify that Dr. John R. Pedrotty M.D. is a contracted provider with my insurance carrier. If Dr. John Pedrotty M.D. has no contract, expressed or implied, with my insurance carrier, I understand that I am individually obligated to pay the full charges of all services rendered to me by Dr. John R. Pedrotty M.D.

_____ 3. **NON COVERED SERVICES**: I understand that Dr. John Pedrotty M.D. contracts with health care service plans for items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by the health care service plans NOT to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Dr. John R. Pedrotty M.D. to obtain necessary health care service plan authorizations.

_____ 4. **FINANCIAL AGREEMENT**: is I agree that in the services provided to the patient by Dr. John Pedrotty M.D., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Dr. John Pedrotty M.D. for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Dr. John Pedrotty M.D. If co-payments and/or deductibles are designed by my insurance carrier or health plan, I agree to pay them to Dr. John Pedrotty M.D. However, it understood and/or the patient primarily responsible for the payment of my bill.

_____ 5. **PLAN**: I agree that I have been given the opportunity to read and receive a copy of Dr. John Pedrotty M.D. notice of Privacy Practices. This practice provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPPA).

_____ 6. **I UNDERSTAND** that I may request a copy of this assignment at any time. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

_____
Patient or Guardian Name (print)

_____
Patient or Guardian Signature

_____
Date

* If an authorization is signed by an individual's personal representative, the representative's authority is based on:

_____
(e.g., state law, court order, etc.)