

## FINANCIAL / OFFICE POLICIES

*The best medical care can be provided only on the basis of mutual understanding.*

*We encourage you to contact our billing office with any questions regarding filing of insurance and your financial obligation to Dr. Proctor.*

*Please be advised that this is not an all-inclusive list.*

**Please initial by each paragraph below indicating that you have read and agree to each.**

**Initial** \_\_\_\_\_ If we participate with your insurance, we are contractually obligated to collect any deductible, coinsurance and / or co-pay at the time of service.

**Initial** \_\_\_\_\_ Dr. Proctor is a participating provider for MEDICARE, IR COUNTY MEDICAID, CIGNA, CHAMPUS / TRICARE, BLUE CROSS / BLUE SHIELD (except HMO), BEECHSTREET COMPANIES, UNITED HEALTHCARE, SOUTHCARE PPO, ECN, and EMI. If you have insurance coverage that is different from these companies, we will file your insurance once as a courtesy, however, if they do not pay within 30 days, any balance due will be your responsibility. **If you have a co-pay stated on your insurance card, we will collect that at the time of your visit.**

**Initial** \_\_\_\_\_ I authorize release of information concerning healthcare, advice, treatment to my insurance company(s), other physicians' offices where I am a patient, a physician's office that I am being referred to or to a surgical facility in preparation for surgery.

**Initial** \_\_\_\_\_ I give my consent for the physicians' office to call my home regarding health care provided by this office and information regarding appointments.

**Initial** \_\_\_\_\_ I understand that it is my responsibility to notify the office if my medical or medication information changes.

*I, the undersigned, authorize payment of medical benefits for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I agree to be responsible for any legal fees and / or court costs incurred as a result of my failure to pay for services rendered.*

**Please print Patient's name :** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient's or Parent/Guardian signature:** \_\_\_\_\_

### **Medicare Patients Only**

**I request that payment of authorized Medicare benefits be made on my behalf to Dr. Proctor for any services rendered to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine if these benefits are payable for related services. The Medicare provider, Dr. Donald C. Proctor, Jr., agrees to accept the charge determination of Medicare as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.**

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_