

PATIENT AGREEMENT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Protected Health Information is generally shared by medical facilities and insurance sureties for the care and treatment of the patient. Authorization must be given by the patient (other than minor child) for the release of information to anyone other than medical facilities and your insurance company. Do you wish to authorize anyone, other than yourself, to have access to your medical information (i.e.; spouse, child, attorney)? If so, whom?

Name: _____ Relationship: _____

REGARDING INSURANCE

Filing insurance claims is a service provided without charge and in no way relieves you of responsibility for your bill. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. If your insurance company has not paid on your claim within 45 days, you will be responsible for the balance. By signing below, you authorize Dr. Thurman's medical office to receive assignment for the insurance payments. If the customary charges are more than the benefits allowed under the responsible party's insurance plan, you agree to pay the difference.

SCHEDULED SURGERIES AND PROCEDURES

Dr. Thurman performs all hospital surgeries *only at Mountain View Hospital*. For any scheduled surgeries or procedures we will contact your insurance company for authorization. You can then expect to receive a fee disclosure form with the estimated fees for your procedure. **All surgical/procedural co-pays and/or deductibles must be paid 5 business days prior to any service being performed or the service will be rescheduled. Private pay fees need to be collected one week in advance of the scheduled service.**

CONTRACT TO PAY FOR MEDICAL SERVICES

All payments, deductibles, and co-payments are due at the time of service. A late fee of 18% interest will be added to your account for any late or missed payments not made by the 15th of each month. You will also be liable for all collection costs and attorney fees incurred in collecting any balance due that has not been paid as agreed. It is understood that any payment received resulting in an overpayment will be refunded to the proper payer. Patient refunds are made at the beginning of each month.

Payment Options: Visa/Mastercard Check Cash

I have read and accept the terms of this agreement.

Signature _____ Date _____

Printed Name _____

Witness _____ Date _____