FINANCIAL GUIDELINES FOR HEALTH CARE SERVICES

Thank you for choosing to receive your health care at our medical office. This document contains important information concerning financial responsibility for services received.

Please present your insurance card at every visit. Copayments are due and payable at the time of your visit. We accept MasterCard, Visa and Discover Card. If you pay by check and it is returned, it will be necessary to apply a $25 fee to your account. Any self-pay balances that are referred to our Collection Agency will incur an additional (20%) twenty percent collection fee.

REFERRALS / SPECIALTY CARE

Your insurance plan may require that prior authorization be obtained for certain services in order to provide reimbursement. Please contact your insurance company to determine referral requirements before receiving services. If the visit requires a referral, you are responsible for obtaining this referral through your primary care physician. A referral is not a guarantee of coverage.

NON-COVERED SERVICES

It is very important that you take the time to read and understand the information provided to you by your insurance company including your member handbook. All insurance companies have limits on the services they cover, and it is extremely important that you know your membership eligibility, benefits, limitations and exclusions under your specific plan. **If we bill your insurance and payment is denied for any valid reason, payment remains your responsibility.**

LABORATORY

Certain lab tests are provided by a third party company. Please be aware that you may be billed separately for these services. If you have questions about this bill, please contact your insurance company. Some insurance companies have identified specific laboratories for you to use. Your insurance company can tell you these arrangements.

WHERE TO GO IF YOU HAVE QUESTIONS

Our billing department is available to assist you with any questions you may have regarding this policy or other customer services issues regarding your balance. They can be reached Monday through Friday, 9 a.m. - 4 p.m. at **1-866-456-1475.** For questions regarding your insurance policy and guidelines call the telephone number on your ID card.

ASSIGNMENT OF BENEFITS

Non-Medicare Patients: I authorize the release of all medical information necessary to process this claim and is pertinent to my medical care. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to ***RiverBend Medical Group***.

Medicare Patients: I request that payment of authorized Medicare/Medigap benefits be made on my behalf to ***RiverBend Medical Group*** for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medical Services, its agents or my Medigap Insurer, any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me is correct. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. **I understand that I may be responsible for any amount not covered by insurance.**

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND ASSIGNMENTS OF BENEFITS. I AGREE TO ABIDE BY THESE GUIDELINES. This will remain in effect for any services provided to me by RiverBend Medical Group.

Patient's Name (Print)	*Patient's Social Security #*
Patient's Signature	*Parent's / Legal Guardian Signature if Minor*
Witness Signature	*Date*