***Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor hereby promise to pay in full this office customary charge for the goods and services rendered to the patient during treatment at this office. I acknowledge that, upon proof of acceptable insurance coverage, this office will file said insurance. I understand that all deductibles, co-insurance, non-covered charges and other items not paid by insurance or other third-party payers shall be due and payable within 30 days of service. I acknowledge and agree that in the event that this office, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the patient and/or the insured and that these benefits will be considered by the office in determining the amounts due as set forth. I acknowledge and agree that the filing of such insurance and other third-party claims is performed as a service by the office and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.***

Patient hereby appoints the office as Patient’s authorized representative to file any necessary claim appeal(s) on Patient’s behalf. In consideration for this appointment, this office agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to this office all insurance benefits on all policies of insurance under which Debtor is an insured. I hereby authorize this office to obtain any information or copies of any accident reports or other document s with regard to such injuries and agree to cooperate with this office in connection with the procurement of any information or documents it deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to this office under the terms of this assignment.

1. ***Assignment to Physicians:*** I hereby assign to all physicians who treat me the benefits due to me for these services covering medical and/or surgical expenses. I agree that should be the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physicians for payment of the entire bill.
2. ***Medicare Consent:*** I certify that the information given by me in applying for payment under Title XVII of the Social Security Act (SSA) is correct. I authorize this office to provide (SSA) or its intermediaries with access to my medical record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that this office provide copies thereof as may be requested.
3. ***Authorization for Release of Information:*** The employees and agents of this office and copy services and electronic claims processing service under contract with this office and any third party billing agents for this office or any of its physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient, to another healthcare provider if the patient was transferred to that facility from this office and to any and all insurance companies or other third-party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this office, and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third-party payers for the purpose of performing pre-certification, concurrent and/or retrospective review and /or other utilization review of any kind.
4. Dr. Sanders will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for reasons indicated below.

**I acknowledge that I have been informed of my rights and obligations as a patient.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**X Signature of Patient/Guardian Date/Time Witness Signature Date/Time**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

**X Print Name Date/Time Print Witness Date/Time**

**If Patient/Guarantor is unable to sign, I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby state that I have been given the authority to**

**sign for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, either expressed or implied and that he or she is fully aware of this authority.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_**

**Signature of Authorized Party Relationship to the Patient Date/Time Witness Date/Time**