Patient Name: _____ **Legal Guardian:**_____

Financial Policy

IT IS YOUR RESPONSIBILITY TO KNOW WHAT YOUR INSURANCE CONTRACT COVERS. Your insurance coverage is a contract between you and your insurance company. We are not a part of that contract. Not all services and supplies are a covered benefit in all contracts. **We urge you to review your insurance policies, particularly relating to well visits, office procedures and immunizations.**

Payment for services rendered, including any applicable copayments, is due at time lime of service unless arrangements have been made in advance. We accept cash, checks, Discover, MasterCard and Visa. We will gladly discuss your proposed treatment costs and any questions you have regarding your insurance.

Any questions you have regarding finance or billing issues should be addressed to the billing department. Our fees are generally considered to fall within the "UCR" (usual, customary and reasonable) range. This applies to companies who pay a percentage, such as 70%. This does not apply to companies who reimburse based on an arbitrary "schedule of fees", which bears no relationship to the current standard and cost of care in this area.

I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full at the time of service unless other arrangements are made in advance with the billing department. I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I authorize payment of medical benefits to Neil A. Patterson, MD., P.A. for medical services rendered.

_____ **Date:** _____

Patient's or Legal Guardian's Signature

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

By signing this form, I consent to **Neil A. Patterson, M.D., P.A.** using and disclosing protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I understand that this disclosure allows sharing of my PHI, which may be sensitive in nature including HIV/AIDS, sexually transmitted diseases, substance abuse, mental health conditions or pregnancy, with other physicians or medical practitioners or entities who may be involved in my care. This disclosure also allows sharing of my PHI with my health insurance company. I understand that these records may contain information from other health care providers, as well as administrative data, which may not be strictly medical in nature. I understand that once information is released to another entity **Neil A. Patterson, M.D., P.A.** is not responsible for any further disclosure by that entity. I understand that the Practice has the right to refuse to treat me if I or my authorized representative do not sign the Consent Form at this time or choose to revoke the consent any time in the future.I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent.

Note: Requests for patient records not related to chain of care from outside entities, such as physicians, legal entities or non-health insurance companies, will require a separate signed authorization from the patient before information will be released.

_____ _____

Signature of Patient or Legal Guardian Date

A copy of this authority shall be accepted as an original.

Updated 11/6/2011