Woods Cardiovascular Internal Medicine Associates, P.C.

Authorization Statement

Patient Name:_____

I authorize treatment by Woods Cardiovascular Internal Medicine Associates, PC.

I authorize the release of any necessary medical information to my insurance carrier that is required for determination of payment for the medical services rendered.

I authorize the release of medical information to other medical doctors or health care providers involved in my healthcare.

All co-pays, deductibles, and unpaid balances are due at time of visit. Should Woods Cardiovascular Internal Medicine Associates, PC. not be participating with my carrier, I agree to pay the difference over and above the allowed amount for services rendered.

I understand that I am responsible for knowing the limitations of my insurance coverage. As a courtesy, Woods Cardiovascular Internal Medicine Associates, PC. will attempt to verify your coverage and estimate the patient's financial responsibility. This is not a guarantee of insurance payment or an exact balance owed for your services. I understand a statement of my charges will be sent to my mailing address unless I otherwise indicate. Past due balances that remain unpaid past 120 days are subject to being placed with an outside collection agency. It is my responsibility to establish payment arrangements with the billing office if I am unable to pay my balance in full at the time of service or upon receipt of my first statement.

Co-pays are due and payable at the time of service. Medicare considers "routine waiver" of co-payments against the law. Many other private insurers have adopted similar regulations which have resulted in legal actions against physicians seeking monetary damages, filing medical license disciplinary complaints, and encouraging criminal investigation and prosecution. Therefore, in order to ensure that Woods Cardiovascular Internal Medicine Associates, PC. Complies with these regulations, waiver will be considered only for financial hardship.

Fees: There is a $15.00 fee for each completed form or letter that you request from your Physician. We ask that this paperwork is picked up at the office upon collection of the fee.
Returned Checks-there is a $25.00 fee for any checks returned by the bank.
Failure to cancel within 24 hours notice or "no shows" will result in a no show charge of $15.00 per appointment.

Testing: I understand that it is the patient's responsibility to check with their insurance companies to make sure all testing is covered at this office. If your doctor ordered a test for you, please call your insurance company and MAKE SURE this test is a covered benefit through Woods Cardiovascular Internal Medicine Associates, PC. *before* your appointment. If you fail to do so and your insurance company does not pay, the balance will become your responsibility.

Signature of Patient/Responsible Party: _____ Date:_____

Signature of Witness _____

MEDICARE PATIENTS ONLY

I hereby authorize the release of any information acquired in the course of my examination of treatment to the Center's for Medicare & Medicaid Services and its agents for services rendered by Woods Cardiovascular Internal Medicine Associates, PC. I request payment be made directly to the provider of care. In addition, I understand that if I request services and am informed that Medicare may not cover, I will sign an ABN form and understand that by doing so, I will be responsible for paying the difference.

Signed:_____ Date:_____