Authorizations, Assignments, Benefits and Acknowledgment

As a condition of and in consideration of servicing the health care needs of (the "Patient"), I (the patient or legal guardian of the patient), hereby acknowledge and agree as follows:

I agree to **present my insurance card at each and every visit**.

I agree that **all insurance co payments and deductibles are due at the time of service**. A **ten (10) dollar billing fee will be assessed** if the co-payments or deductibles are not paid at the time of visit.

I certify that the personal and insurance information given at the front desk is accurate and correct. The insurance coverage information set forth is in effect as of the date of this form.

Family Medicine of Stark County has contracts with several insurance carriers. Therefore; Family Medicine of Stark County requests copies of all insurance cards. Please check with our staff to see if we are able to directly bill your insurance carrier.

I hereby authorize payment by my insurance carrier directly to Family Medicine of Stark County and irrevocably assign to Family Medicine of Stark County all payments for medical services rendered and all major medical benefits.

I authorize any insurance carrier, physician or Family Medicine of Stark County employee to release information or medical records which are reasonably necessary to process any claim or which may have a bearing on benefits payable by any carrier or benefit plan.

I understand and agree that I am financially responsible for all charges regarding the servicing of my health care needs regardless of any insurance claims or coverage. I understand that all co pays and deductibles are due at the time of service. I understand that I must pay **20% of my outstanding balance at the time of my visit**. I understand that there will be a fee charged on all returned checks. If my account is referred to an attorney for collection or other legal action, I agree to pay all reasonable attorney fees and expenses of collection.

I understand that it is my responsibility to cancel my appointments, **at least 24 hours** prior to my appointment. I understand Family Medicine of Stark County reserves the right to charge a fee or dismiss me from the practice for missed appointments.

I agree that a photocopy of this signed form is as valid as the original and may be used in place of the original signed form.

This agreement will remain in effect until revoked by me in writing.

_____ _____

Signature Date

11/09